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ABSTRACT

This monograph, the fourth in a series of five, provides training information for hospice staff in improving interdisciplinary team functions and humanistic care provisions. Its purpose is to prepare a skilled team of trainers with information about hospices that is relevant to hospice interdisciplinary team training and to document experiences in training hospice staff in interdisciplinary team functions. Chapter 1 reviews the purpose of the training and the trainer's role and provides a checklist of final preparations for the formal training sessions. Each chapter, in chapters 2 through 5, deals with one of the major interdisciplinary team training categories: goals, roles, structure, and procedures. Each of these training categories is outlined in a similar fashion: introduction (explains the meaning of the category and its relevance to hospices), hospice specific examples and issues in training (identifies related issues frequently seen in hospices to provide the trainer with insight into problems faced by hospice staff), approaches to training (provides background information for the trainers, specific session outlines with preparatory materials recommended for trainers and participants, and examples from hospice training experiences), and selected references for training. Following a bibliography are definitions and tables of contents of the five monographs. (YLB)

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THE ELM INSTITUTE

INTERDISCIPLINARY TEAM TRAINING: CONTENT AND METHODOLOGY

Monograph 4 in a Series:
INTERDISCIPLINARY TEAM TRAINING AND HUMANISTIC PATIENT CARE FOR HOSPICES

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INTERDISCIPLINARY TEAM TRAINING: CONTENT AND METHODOLOGY

Monograph 4

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An ELM Institute Project:

Lee E. Mortenson
President

September 1981

MONOGRAPH 4

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FOREWORD

The ELM Institute is a not for profit corporation, founded to conduct research and education in established and emerging areas of health care delivery and policy. From the outset, one of the Institute's three major areas of interest has been terminal care, the others being cancer care and long term care of the impaired elderly.

While terminal care must function in the established health care delivery arena, its goals are substantially different. Instead of cure and rehabilitation, it acknowledges death and seeks to assure physical, spiritual, emotional and social comfort. We reasoned that this type of dichotomy would present organizational, structural, economic, and personnel difficulties as these two approaches were merged. These issues and their management are primary areas of interest to Institute staff.

For these reasons the Institute was pleased to receive the DHHS award to study the interdisciplinary team training and humanistic care training needs of terminal care programs. I believe the results contained in these volumes confirm our mutual judgment that alternative modes of health care delivery require unique staff interactions and support mechanisms in order to survive and meld with the current care system. Further, I believe you will find that the concepts utilized in this model for training and team development have broader programmatic applications than terminal care.

The Institute will continue to test and refine the model, and is willing to work with those programs who require specialized expertise or who face unique circumstances. In many other cases, it is our hope that these modules will provide sufficient information to an informed and experienced process consultant.

From the Institute's perspective, we intend to continue similiar research and development projects in health care delivery and in policy formulation. We are pleased to have had an excellent opportunity to further our investigations and to work with an excellent group of advisors and collaborators.

Lee E. Mortenson
President
ELM Institute
Rockville, Maryland
August, 1981

PREFACE

Purpose of the Series

The purpose of this series of monographs is to assist hospices in improving their quality of care, through enabling them to improve their ability to meet the needs of their patients and families. Objectives include: improving the functioning of the interdisciplinary team, integrating the patient and family into the team, ensuring the appropriate utilization of professional services, and improving staff awareness and capability of providing humanistic patient care. These objectives may be attained through a training program for hospice staff described in the monographs.

The goals and objectives of the training program relate directly to those of hospices. Both direct attention to the whole person - patient, family member, or staff member - individually and as a group member. Both attempt to integrate the physical, psychosocial and spiritual approaches to care. Both combine scientific knowledge, skills, affective awareness, and interdependent coordination of activity to achieve an orientation to comfort and growth for all those involved. Hospices, having already made significant progress toward their goals, can expect the training program to enable them to approach these goals more quickly, more comfortably, and more effectively.

Hospice staff members need to be highly skilled in both the technical and the humanistic aspects of health care. These monographs acknowledge the need for high quality professional skill on the part of all staff members but do not address it. Training information in this aspect is assumed to be already in place. This series of monographs was developed to fill an acknowledged gap in training information for hospices, that is, training information in improving team function and humanistic care provision.

The monographs provide a significant contribution to these hospice activities. They provide factual information, approaches, and methods for qualified trainers to utilize their existing knowledge and skills successfully in the unique environment of the North American hospice. The series is intended primarily for the use of trainers assisting hospices, and not as a self-help guide for hospices; however, all or parts of the series may be a helpful resource not only to hospices and hospice trainers but also to others concerned with the interdisciplinary and humanistic qualities of hospice care.

These monographs are working documents. The information they provide has been developed by trainers who are leaders in the field, tested in two demonstration hospices, and then modified on the basis of these tests. The developers anticipate that additions and variations will be appropriate over time and through continuing use of the document.*

Review of the Series

This series of five monographs was written by the ELM Institute under the general title: Interdisciplinary Team Training and Humanistic Patient Care for Hospices. The monographs, outlined below, address the following topics:

Monograph 1: Guide for Hospices
Monograph 2: Guide for Trainers
Monograph 3: Training Program Design
Monograph 4: Interdisciplinary Team Training:
    Content and Methodology
Monograph 5: Humanistic Patient Care Training:
    Content and Methodology

Monograph 1, Guide for Hospices, is directed to hospice administrators. It may, however, be of interest to trainers and others. It describes teams, team function and the provision of humanistic patient care, and assists hospices to determine whether or not they have reached the state of development needed for this training. It identifies the objectives of the training and the anticipated benefits to the hospice, as well as the role of the hospice administration in the training and its financial and other obligations. In particular, it assists hospices to recruit and select one or more qualified trainers from outside the hospice organization to conduct the training. It also supplies useful suggestions to hospices based on ELM's hospice training experience.

Monograph 2, Guide for Trainers, is directed to "outside" trainers who may be invited by a hospice to conduct its training, although it may be of interest to others, as well. It is recommended that all trainers anticipating work in hospices read this monograph, regardless of their prior experience, in order to learn more about the unique features of a hospice and the implications of training in the hospice setting. The document provides background information about the hospice concept, models, components, standards, and staff characteristics. It also assists trainers to determine whether or not the hospice and the trainer match sufficiently well for the training to be successful, and to recommend the appropriate staff members to be trained. The role of the trainer is reviewed and suggestions from ELM's hospice training experience are offered.

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* Reports of experiences with the monographs and any recommended additions or modifications to them would be welcomed by the developers - the ELM Institute, 11600 Nebel St., Rockville, Maryland, 20852 - for inclusion in future revised editions.

Monograph 3, Training Program Design, is directed primarily to the trainer(s) who has contracted with the hospice to conduct the training. It will also be useful to hospices in working with the trainer in developing their programs. It may also be of value to others. The monograph provides a detailed statement of goals and objectives of the training, and describes the steps of the training design: orientation of staff, initial data collection, identification of issues specific to the hospice concerned, preparation of reports, feedback of the reports to the staff, confirmation and prioritization of issues, and joint staff/trainer selection, design and planning of a customized training program to address these issues. Again, examples from hospice training experience are reported.

Monograph 4, Interdisciplinary Team Training: Content and Methodology, is again directed to the trainer, although it may also be of interest to hospices and others. It contains the materials needed to conduct the training, and includes examples of issues and approaches to interdisciplinary team training in the hospice setting. It is not intended to limit the trainer but to assist by providing hospice information, outlines of successful training sessions, examples from hospice training experience, and relevant literature resources. It contains checklists and hints that may be useful to trainers, particularly in their first hospice training experiences. The monograph is divided into four sections, covering the major interdisciplinary team training categories: goals, roles, structure, and procedures.

Monograph 5, Humanistic Patient Care Training: Content and Methodology, provides trainers with information concerning humanistic patient care training in hospices and is similar in structure to that in Monograph 4. Again, although directed to the trainer, it may also contribute to understanding by hospices and others of the humanistic approach and what training in humanistic patient care entails. The document provides examples from hospice experience in humanistic values and orientations, in issues relevant to training, and in humanistic training in hospices. There are sections on background information, checklists and hints for trainers, and outlines of successful training sessions. Pertinent references to the literature are included. The monograph addresses the definition of humanistic patient care and the topics: psychosocial variables in working with dying patients; patient and family needs, environment and rights; patient/staff relationships, including listening and stress management techniques; staff/staff relationships and staff relationships with other health professionals, including listening and communication skills; and monitoring of humanistic patient care provision.

It is not essential for hospices or trainers to acquire the complete series. Each monograph was prepared to address a different audience and to be complete in itself. This approach however, necessitated the inclusion in more than one monograph of certain sections common to more than one audience or title. The reader of the entire series will be well aware of these repetitions.

Review of the Project

This series of monographs was developed by the ELM Institute under a two-year contract with Health Resources Administration, Department of Health and Human Services, entitled: "Assessment of Staffing Patterns and Development of Interdisciplinary Team Training and Humanistic Patient Care in Hospices". The contractor was the ELM Institute, with David J. English, D.B.A., its Executive Director, the project director and Dottie C. Wilson, its Hospice Group Director, the associate project director.

A Panel of Consultants was named to provide technical assistance and to assist in the development of a training program plan and an evaluation plan. Some members of the panel conducted hospice training sessions. An Ad Hoc Review Committee was named, representing major health care associations and approaches, to provide a broad perspective to the work undertaken and to assess its applicability to the health care system.

An analysis was performed of documents describing the organization and staffing patterns, including staff characteristics, in current U.S. hospices. The documents analyzed were the more than 250 applications by hospices to the Health Care Financing Administration for waivers of certain reimbursement regulations. This analysis, along with bibliographies and assessments of the anticipated impact of training on hospices, was published in July 1980 in a report entitled: An Assessment of the Existing Staffing Patterns and Personnel Required in a Hospice to Deliver Interdisciplinary Patient Care and the Problems Related to Delivering Humanistic Care to Hospice Patients.

ELM staff and Panel of Consultant members developed a training program plan, a statement of training goals and objectives, and, with the subcontractor, an evaluation plan. To test the plan, training was conducted in two demonstration hospices, one an independent home care program and the other an inpatient and home care program within a hospital. The training was conducted by certain members of the panel of consultants with ELM coordination. Those trained included steering committees, a management team and patient care teams. The training was evaluated by the ELM Institute's subcontractor, Perry Cohen Associates, using both impact and process evaluation techniques.

Acknowledgements

The smooth conduct of the HRA contract and the significance of its results have been made possible by the availability and assistance of the HRA Project Officer, Mr. Thomas Aschenbrener. ELM appreciates very much his contribution to the success of the project and to the series of monographs.

All those who contributed to the project and to the series of monographs are listed in the Appendix to this volume. ELM extends sincere thanks to each of them, and in particular acknowledges the significant contributions of John A. Hackley, M.S.W., Mark S. Plovnick, Ph.D., Charles Seashore, Ph.D., and Terence F. VanOrshoven, Ph.D., to the development of the monographs.

The success of the training program demonstrations was in large part due to the enthusiasm, cooperation and support of the leadership of the two hospices concerned. Special thanks are due to Anne Kirschner Katterhagen, R.N., B.S.N., Executive Director of Hospice of Tacoma, Tacoma, Washington, and both Maryanne Fello, R.N., Director of Hospice Care, and Madalon Amenta, Dr.P.H., Director of Research and Education, Forbes Hospice, Pittsburgh, Pennsylvania, for their interest and assistance in the training demonstrations.

The ELM staff, including senior associates, research associates, and support staff, have been most helpful throughout the project and monograph preparation. We appreciate it.

David J. English, D.B.A., Project
Director, and Dottie C. Wilson,
Associate Project Director.

September 1981

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CHAPTER I

INTRODUCTION

A. Purpose of the Monograph

The purpose of this monograph is to provide a skilled team trainer with information about hospices that is relevant to hospice interdisciplinary team training, and to document what experience there has been in training hospice staff in interdisciplinary team function. (It is not intended to be a step by step instruction manual for hospices or for unqualified trainers.)

Monographs 1, 2, and 3 deal with the hospice preparation for training, the selection and orientation of the trainer, the identification and prioritization of training issues, and the development of a training program to meet the needs of the particular hospice. This monograph addresses the interdisciplinary team training itself, its organization or design, the role of the trainer, and the detailed information needed by the trainer in conducting the training in hospices. With this background and the trainer's own knowledge and skills, the trainer should be in a position to provide excellent, successful training with confidence and enthusiasm.

Some trainers consider the first training session to be one which reviews the feedback report and plans the training topics. It is important to recognize that this session is, in fact, a training session. However, in this series of monographs, the feedback session is outlined and discussed in Monograph 3, Training Program Design, Chapter IV. In interdisciplinary team training, as covered in Monograph 4, the first formal training session is the first session on goals.

Although this monograph draws on a variety of literature resources and the experience of both ELM and others, one major reference appears to apply best to the needs of hospice teams and is used extensively throughout this document. Acknowledgement is made to the book and to one of its authors, Mark S. Plovnick, Ph.D., for training outlines and for assistance provided in the preparation of this monograph. The application of this approach and its modifications to hospices also appears throughout the document. The citation is: Rubin, I.M., Plovnick, M.S. and Fry, R.E., Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Company, 1975.

Each of the following chapters (II, III, IV, and V) of this monograph, then, deal with one of the major interdisciplinary team training categories:

Training Category 1. Goals
Training Category 2. Roles
Training Category 3. Structure
Training Category 4. Procedures.

Each of these training categories is outlined in similar fashion, as follows:

A. Introduction: explains the meaning of the category and its relevance to hospices.

B. Hospice Specific Examples: provides examples of the category in hospices, particularly for the various groups involved - patients, families, staff members, disciplinary or professional groups, teams, administrations, etc. to identify the diversity of needs in hospice settings.

C. Issues in Training: identifies issues related to the category frequently seen in hospices, to provide the trainer with insight into the problems hospice staff members face.

D. Approaches to Training: provides background information for the trainer concerning the timing and structure of the training and the special problems that may be anticipated in training hospice staff members in the category. The relationship between the identified issues and the training session topics is clarified. In addition, specific sessions are outlined, with preparatory materials recommended for both the trainer and the training participants. These are intended as guidelines (not as restrictions) to assist the trainer in planning the sessions. Then, excerpts from actual hospice training sessions are presented, to provide the trainer with a flavor of the sessions.

E. Selected References for Training: lists suggested resource materials from the literature intended for the use of the trainer, the training participants, and others interested in interdisciplinary team training.

This chapter, Chapter 1, reviews the purpose of the training and the role of the trainer. It also provides a list of suggestions to the trainer in making the final preparations for the formal training sessions.

B. Purpose of the Training

The focus of the interdisciplinary team training is to improve both the effectiveness and efficiency of hospice teams. The team development activities to be conducted are intended to facilitate learning and encourage the exploration of how team members may function more interdependently in order to provide both the most responsive and comprehensive care to patient and family and the most helpful support to the staff. See also Monograph 3, Chapter II.

Interdisciplinary health team training is discussed in the literature, with several approaches described. Few, if any, however, relate specifically to hospices.* Important information that has been adapted successfully to hospices is contained in the following works:

- Bottom, P.A., Bottom, W.D., DiMicco, W.A.P., Elledge, C.D., Retief, Z.M., Setzer, F.B., Stephens, G.G., Thompson, R.W., and Young, W.O., "Curriculum Development for Interdisciplinary Health Team Education", Alabama Journal of Medical Science, 15(1): 98-100, January 1978.
- Dyer, William G., Team Building: Issues and Alternatives, Reading, MA, Addison-Wesley, 1977.
- Eichhorn, S.F., Becoming: The Actualization of Individual Differences in Five Student Health Teams, Bronx, NY, Institute for Health Team Development, Montefiore Hospital and Medical Center, 1974.
- Rubin, I.M., Plovnick, M.S., and Fry, R.E., Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Company, 1975.

Although the experienced team trainer will be familiar with this material, this monograph provides the unique perspectives of hospices. The approach taken in the monograph is a combination of the previous experience of the ELM Institute, its experience with the two demonstrations, the experience of its trainers, and a review of the literature.

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* Wilson, D.C., English, D.J., and the Research Staff of the ELM Institute, An Assessment of the Existing Staffing Patterns and Personnel Required in a Hospice to Deliver Interdisciplinary Patient Care and the Problems Related to Delivering Humanistic Care to Hospice Patients, the ELM Institute, July 1980, Part B, pp. 52-64.

The design developed here addresses the known needs of currently operating hospices. The latitude in the training program outlines and the alternatives presented in this monograph are a function of both the acknowledged existing skill of the trainer and the need to adapt the design to each hospice. The issues developed during the data collection, the organization of the hospice itself, and composition of the team to be trained are all variables in determining the training design for a particular hospice.

C. Role of the Trainer

As described in Monograph 2, Chapter IV, the intended role of the trainer is to facilitate learning and to encourage team members to explore how they may function more independently. Through this process, it is anticipated that team members will provide more responsive and comprehensive care to patients and families and more support for each other.

1. Trainer Role as Facilitator

The role of the trainer is that of facilitator, that is, one who serves the group, concerned more with process than content. It is not the role of the trainer to provide solutions to issues but rather to assist the group in reaching consensus of the solutions it has developed.

As facilitator, the interdisciplinary team trainer assists the team or teams to work through sessions on goals, roles, structure and procedures, and specifically to assist the team to:

- Reach consensus on the mission of the organization, identify personal goals, resolve goal conflicts, and prioritze goals to achieve the organization's mission,

- Identify, clarify, and negotiate individual roles represented within the team,

- Review critically the team's and the organization's procedures and norms, and develop clear participatory procedures for more efficient and effective decision making, and

- Identify constraints within the organization structure which have an impact on personal/team effectiveness, and develop problem solving strategies,

- Become more cohesive and more supportive of its members.

2. Trainer Responsibilities and Activities

Specific responsibilities and activities of the trainer may include the following:

- To assess team function and diagnose blockages to effective collaboration,
- To create an open, problem solving climate with trust and support among members,
- To increase the level of commitment and sense of responsibility for tasks,
- To assist in the identification of team issues and in the development of team building objectives (see Monograph 3),
- To provide impartial feedback on team performance and process,
- To assist in the identification and resolution of intragroup problems,
- To provide resources and skills not available within the group, and
- To develop skills within the team, including skills in self-monitoring techniques.

The successful interdisciplinary team trainer will focus on facilitative behaviors which encourage open discussions while keeping participants directed to the tasks. Avoiding, if possible, direct open conflict between participants (until the group is more comfortable together and with facilitation) the trainer's role is to assist the team in dealing constructively with conflict, identifying and clarifying key issues, and becoming skillful in the ongoing process of problem exploration and resolution. Participation from all participants should be encouraged within a level of comfort; supervisory members should not be permitted to dominate. The trainer not only should ensure that the team understands the trainer's role but also should behave in a manner which enables the group to develop confidence in him/her.

D. Preparation for Training Sessions

Interdisciplinary team training begins with collecting data, determining the training program design, and scheduling the actual training sessions, as described in Monograph 3. This section deals with detailed arrangements that need to be finalized before the formal sessions begin.

It is recommended that the trainer prepare a checklist of these details after absorbing the information contained in the rest of this monograph. The checklist should be in two parts, one for the opening session, and the other for all sessions. It might include the items shown in Exhibit 1, following.

EXHIBIT 1

CHECKLIST

First Session

_____ Location identified and secured.

_____ Dates and times for all training sessions confirmed and scheduled.

_____ Participants identified and confirmed for continuing involvement in the training.

_____ Trainer knowledgeable about constellation of group (i.e., ratio of supervisory staff to general staff, number of teams to be trained).

_____ Description of trainer's role as facilitator within the training process prepared for presentation to the group in the first session.

_____ List of responsibilities of the participants prepared and duplicated (if to be used).

All Sessions

_____ Relevant monograph materials reviewed prior to each session.

_____ Audiovisual and/or special equipment or supplies requested well in advance (confirm availability the day before the related training session).

_____ All assignments, handouts, etc. prepared and, if necessary, duplicated.

_____ "Icebreaker" exercise prepared in the event required (may be necessary if teams from different shifts are being trained together, or if major cliques or serious supervisor-staff conflicts prevent useful interaction between group members. Participants are already likely to consider themselves a "team" and any need for an icebreaker would have been identified during the issue identification data collection.)

As it is recommended that the opening session deal with goals, this is the subject of the next chapter, Training Category 1: Goals. It begins with a discussion of the importance of goals in team development in general, and in hospice interdisciplinary team training in particular. The trainer is urged to read this material carefully in order to correlate his or her existing knowledge of training in goals with the uniqueness and problems to be found in hospice settings.

CHAPTER II

TRAINING CATEGORY 1: GOALS

A. INTRODUCTION

Goals (or purposes, or objectives) give direction to an organization, to a team within that organization, and to the individuals making up the team. In order for the organization to operate effectively and cohesively, some level of congruity must be reached between the goals of the individual, the team, and the organization. All organizations, including hospices, have missions and goals. From these, measurable objectives (performance goals) and action plans should be developed.

Ideally, the mission and goals of the organization, stated in broad general terms, are transposed by each team into specific goals and sub-goals of particular application to that team which are shared by all team members. Some team goals relate to team function, others to the task of the team, such as patient and family care. The degree to which the individual team members adopt the team's goals directly affects their enthusiasm, level of participation and, in fact, their length of service.

In addition, the goals of each patient and family (whether or not those of the patient and those of the family are congruent) significantly affect the team's goals and activities in relation to that patient and family.

Within a hospice environment, then, goals exist - whether or not they are specifically defined - for a variety of individuals and groups:

- Patients,
- Families,
- Individual staff members,
- Groups of professionals or disciplines,
- Interdisciplinary teams,
- Organizational representatives of the hospice, and
- Organizational representatives of a larger institution of which the hospice may be a part.

One of the purposes of interdisciplinary team training is to identify the goal or goals of all these individuals and groups and to reach congruity among them. Further, the agreed upon goals should be prioritized in terms of both:

- Importance: with a balance reached between the various identified goals, and
- Time: with short term and long term goals identified.

Finally, measurable objectives (performance goals) with action plans or time frames need to be developed to manage the team's progress toward the identified goals.*

This chapter addresses these dimensions of goals under the following headings:

- Hospice Specific Examples: Goals
- Issues in Training: Goals
- Approaches to Training: Goals
  - Background Information for Trainers
  - Outline of Training

    Session 1. Goal Setting: Definition, Clarification and Congruity

    Session 2. Goal Prioritization and Performance Goal Development

    Session 3. Performance Goal Prioritization and Action Plan Development
  - Examples from Hospice Training Experience
- Selected References for Training: Goals

B. Hospice Specific Examples: Goals

Some examples of goal statements frequently encountered in hospices may be useful to trainers in preparing for hospice training. Trainers are advised, however, to avoid placing value judgments on these goals, or to identify these examples as "good" or "bad" goals, but rather to utilize them to identify goal issues.

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* For further information on the dimensions of goals, see: Ducanis, A.J. and Golin, A.K., The Interdisciplinary Health Care Team, Germantown, MD, Aspen Systems Corporation, 1979.

The variety of the goals described suggests considerable diversity. For example, diversity can be seen in hospices not only between patients but also in the same patient over time. A patient may wish to be with his or her entire family and group of friends early in the progress of the disease, and later may begin to separate from these associations. This may also be seen in the family members. Similarly, a staff member may seek diversionary activities for a patient while the patient is able to enjoy them, and then change to concentrating on physical comfort, emotional support, and sitting with the patient as death approaches.

Exhibits 2 through 7 provide examples of:

- Patient Goals,
- Family Goals,
- Personal Goals of Staff and Volunteers,
- Disciplinary or Professional Group Goals,
- Team Goals, and
- Organizational Goals.

EXHIBIT 2

Examples of Patient Goals

- to be free of physical pain
- to have psychosocial and spiritual needs met
- to be cared for by family
- to preserve a sense of normalcy for the remaining period of life
- to not be a burden on the family
- to remain at home for as long as possible
- to maintain as much control as possible over mind, body and the care being delivered
- to die a dignified death without any heroic life saving interventions
- to die at home
- to die at the hospital
- to spend as much time with the entire family as possible
- to be involved to the fullest with closest friends
- to ensure the family isn't told that condition is terminal
- to be able to attend daughter's wedding

EXHIBIT 3

Examples of Family Goals

- to ensure the dying person is free of pain
- to get the patient out of the house so the rest of the family can go on with their lives
- to learn to utilize the hospice team most appropriately for the support it needs
- to become more comfortable about talking about death with the patient or other family members
- to be able to accept the psychosocial supports available through hospice
- to try to handle this situation independently
- to keep the person at home until death
- to get the children out of the environment for the next couple of weeks to protect them from the "horrors" of the "dying environment"
- to maintain control
- to help the patient achieve a dignified death
- to be sure the patient doesn't learn of the seriousness of his/her condition
- to keep all visiting to a minimum so that the patient can get some rest
- to provide total care of the patient
- to postpone own needed medical care while the patient is alive
- to avoid emotional detachment from the patient before the patient's death

EXHIBIT 4

Examples of Personal Goals of Staff and Volunteers

- to do something worthwhile
- to cope more effectively with facing frequent and inevitable deaths
- to improve the care provided to dying persons
- to prepare for own death
- to become nationally recognized in the hospice field
- to provide the kind of whole person/patient/ family care not previously provided when own family member died
- to learn something about the psychology of death
- to have the experience on resume for future oncology job application
- to convert patients to own religion before they die
- to devote positive energy to those who need it most
- to provide some spiritual comfort to patients while caring for them as a health professional
- to practice detailed bedside nursing care that may be needed but is frequently not possible in other health care settings

EXHIBIT 5

Examples of Disciplinary or Professional Group Goals

- to establish greater rapport with physicians than had previously been permissable in more traditional health care settings (nurses)
- to increase the staff's knowledge of the psycho-social aspects of the dying process (social workers)
- to provide a service equally as valuable as that of the paid staff (professional volunteers)
- to become so indispensable to this operation that paid employment will be offered (volunteers)
- to educate colleagues in the community (physicians, nurses, social workers, etc.)
- to generate new referrals for own practices (physicians)
- to ensure that nursing care is recognized as the primary function of hospice (nurses)
- to ensure that the emphasis on counseling is the feature of the hospice that distinguishes it from other health care (social workers, counselors)
- to maintain complete dominance in patient management decisions (physicians)
- to assist patients to face death with all their spiritual forces (chaplain)
- to improve terminal care (nurses)
- to develop new approaches to working with bereaved families (social workers)
- to acquire better social work skills in order to provide more comprehensive care (nurses)
- to spiritually prepare patients for death in the religious tradition (local clergy)
- to provide the caring physician support that the dying person needs (physicians)
- to provide comprehensive, sensitive, skilled nursing care (nurses)
- to enable patients to be as mobile as possible (physical therapists)
- to provide state-of-the-art pain and symptom management (physicians, nurses)
- to provide continuity of care of patients through initial diagnosis, aggressive therapy, terminal diagnosis and terminal care (physicians)

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EXHIBIT 6

Examples of Team Goals

- to function smoothly as a team
- to provide improved patient care through the interdisciplinary team approach
- to have a good time together
- to improve efficiency (and reduce workload)
- to ensure team member satisfaction
- to acquire new and better skills in caring for the dying
- to educate one another in areas of individual specialization
- to become comfortable with the sharing of roles
- to incorporate the patient and family into the team, as team leaders
- to care for all patients and families in need of hospice, regardless of ability to pay
- to utilize other team members with special skills to better meet patient/family needs

EXHIBIT 7

Examples of Organizational Goals

- to provide improved quality of terminal care
- to provide cost effective care to terminally ill patients and their families
- to recruit and utilize more professional volunteers
- to obtain the maximum reimbursement possible
- to establish an educational center
- to meet the standards established by the National Hospice Organization
- to ensure the financial viability of the hospice program
- to become larger than a competing hospice program in the community
- to expand services
- to expand the referral base
- to gain a national reputation through conducting major research projects

C. ISSUES IN TRAINING: GOALS

Given the myriad goals to be found in the hospice setting it is not surprising that the environment is replete with goal related issues - between individuals, within teams, between teams, from professional group to professional group, among patients and families, and between patients and their care givers.

Four goal issue areas are identified:

- Goal Ambiguity/Clarity
- Goal Prioritization
- Goal Agreements/Contracting
- Goal Conflict Identification/Management.

For each of these, goal problems may occur for individuals, teams, and organizations and between or among any or all of them. The following matrix (Exhibit 8) demonstrates graphically the many possible interrelationships.

EXHIBIT 8

Relationships of Goal Issues to Individual and Group Goals

PROCESS PHASES OR ISSUES	INDIVIDUAL AND GROUP GOALS					
	Patient Goals	Family Goals	Staff Personal Goals	Prof. Group Goals	Team Goals	Hospice Goals
Goal Ambiguity/ Clarity						
Goal Prioritization						
Goal Agreements/ Contracting						
Goal Conflict Identification/Management						

Experienced trainers, although fully cognizant of goal issues, may benefit from a review of illustrations of such issues that are most frequently found in hospice settings. Hospices demonstrate goal problems both because they are new developments and because they are interdisciplinary in nature. Some of these problems may be unique to hospices.

The illustrations below are listed under the four goal issue areas noted above.

1. Illustrations of Goal Ambiguity/Clarity Issues

PROCESS PHASES OR ISSUES	INDIVIDUAL AND GROUP GOALS					
	Patient Goals	Family Goals	Staff Personal Goals	Prof. Group Goals	Team Goals	Hospice Goals
Goal Ambiguity/ Clarity			✓		✓	✓

(a) Illustrations of Staff Personal Goal Ambiguity Issues

- A staff member interprets team activity to mean spending considerable time with other team members discussing their personal problems, while the patients and families go unattended.
- A staff member, an avid supporter of euthanasia, came to hospice with the belief that this is what hospice is all about. Receiving no endorsement for this notion, the staff person must now re-evaluate his goals for being in the environment.
- One young nurse is attracted to the hospice concept in that it is "humanistic nursing care"; however she is continually distraught at the number of deaths in the environment and questions whether or not she has what it takes.
- One social worker wishing to make his own role more clearly understood by other team members presents his views in a manner which alienates other team members. A better understanding of his own goals would have assisted this person in conveying those views.

(b) Illustrations of Team Goal Ambiguity Issues

- One hospice team is having difficulty operationalizing an ambiguous goal such as "to provide humanistic patient care to hospice patients/families".
- Another hospice team defines its short term goals in relation to patient care while its long term goals relate to maintenance of the team. This overly simplistic line of demarcation creates problems when members leave the team.
- One hospice team within a hospital, anxious to elevate its status in the eyes of other hospital workers, came to feel very self important, negating its ability to influence others.
- New arrivals to one hospice team find the team's goals so ambiguous that they are confused as to just what the tasks are.

(c) Illustrations of Organization Goal Ambiguity Issues

- At the risk of "going under", one hospice accepts all patients regardless of ability to pay and is unable to find a source of money to keep itself financially viable.
- One hospice feels its responsibility to the community involves the care of all terminally ill patients without having the variety of skills or number of staff to do so.
- One hospice chose to serve cancer patients 16 years or older only. This decision brought an uproar from the community which sent the organizing members back to the conference room to re-evaluate their goals and the potential to meet them as stated.

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2. Illustrations of Goal Prioritization Issues

PROCESS PHASES OR ISSUES	INDIVIDUAL AND GROUP GOALS					
	Patient Goals	Family Goals	Staff Personal Goals	Prof. Group Goals	Team Goals	Hospice Goals
Goal Prioritization				✓	✓	✓

- Though the importance of comprehensive staff education is recognized, education is not reimbursable, so compromises are made.

- Though it was recognized that patient care meetings, with all team members participating, is essential to the provision of quality hospice care, the high patient census at one hospice occasionally precluded the convening of patient care meetings because staff were so busy.

- One hospice is greatly perplexed because the need in their community far exceeds their ability to meet the needs at this time. The hospice is considering a "rapid expansion" of staff to achieve a goal of meeting the needs of the community's terminally ill, recognizing that the potential dangers of such rapid growth include compromised quality of care. The nurses, in particular, oppose rapid growth.

- Several hospitals attempting to develop a consortium to provide hospice services, are so concerned with "fair shares" that the division of services proposed does not truly reflect quality interdisciplinary hospice care.

3. Illustrations of Goal Agreements/Contracting Issues

PROCESS PHASES OR ISSUES	INDIVIDUAL AND GROUP GOALS					
	Patient Goals	Family Goals	Staff Personal Goals	Prof. Group Goals	Team Goals	Hospice Goals
Goal Agreements/Contracting			✓	✓	✓	✓

- Physicians, worrying about having patients becoming addicted to drugs, do not follow the hospice protocols about drug regimens.
- A physician, not wanting deaths reported under his name, transfers patients to the medical director of the hospice within days of their deaths.
- A physician insists on maintaining control of a patient's care at home, but refuses to make house calls.
- An administrator, although anxious for the hospice to be financially independent, applied for foundation funding and promoted public fund raising so that the quality of care is continued at a high level.
- A volunteer, whose goal was initially to ensure religious conversions of all hospice patients, agreed to abide by the hospice policy of meeting patients where they were philosophically and not attempting to change them.
- The nurses on one hospice team agreed to utilize and work with the social worker and chaplain rather than attempt to provide the care in all areas for all patients.

4. Illustrations of Goal Conflict Identification/Management Issues

PROCESS PHASES OR ISSUES	INDIVIDUAL AND GROUP GOALS					
	Patient Goals	Family Goals	Staff Personal Goals	Prof. Group Goals	Team Goals	Hospice Goals
Goal Conflict Identification/Management	✓	✓	✓	✓	✓	✓

(a) Illustrations of Intra-Individual Goal Conflict Issues

- A patient wants to go home from an inpatient hospice unit but doesn't want to be a burden on the family.
- One nurse wishing to meet the needs and wishes of a patient she cares for is confused when she learns that the family has a different set of needs and wishes. Her goal is to meet the needs of both.
- Another nurse feels she provides the most compassionate hospice care when she puts a great deal of herself into

her work. However this results in an overwhelming sense of loss at the time of death. She then decides to take care of herself and hold back a bit but by doing this she feels she is not delivering the best care possible.

(b) Illustrations of Inter-Individual Goal Conflict Issues

- A dying father wanting to share as much of his remaining time with his children as possible learns that his wife is preparing to send the children away for awhile.
- A dying father in an inpatient hospice wants to see his teenage son with whom he has had disagreements, but the son feels hatred toward his father and refuses to visit.
- Non-religious patients attempting to achieve comfort are continually approached by volunteer spiritual persons attempting death bed conversions.
- A home care nurse rushes to the home when her patient is dying in the middle of the night, causing her husband to be angry and antagonistic to her job.
- To write the paper on death and dying for her sociology night course, a nurse interrogates patients beyond their strength and interest.

(c) Illustrations of Individual-Group Goal Conflict Issues

- An individual hoping to cope more effectively with death is not receiving the necessary supports within the team.
- A patient's family begins to make elaborate plans for a hectic two week tour of Europe when the patient indicates she is more interested in remaining in a familiar environment with familiar friends.
- An administrator sees that hospice is a highly visible way of establishing a name for herself in the community and consequently sometimes loses sight of the larger organizational goal.
- The family has moved to a small apartment and sold the house as the dying mother is in a hospital hospice unit but she wants to come home and there is now no room for her and no wish for her return.
- A patient with lung cancer but still relatively healthy objects to the family "screening" and "discouraging" visitors, wanting to see these persons while still able to do so.

- A patient wants the staff to end his life but the staff members know this is illegal.
- A dying individual finds himself vying with the family for control over his care, resulting in the need for institutionalization to ensure more control by the patient.
- A dying wife in a hospital has a great many thoughts and fears to share with her husband about death but the husband cannot be there because of the hospital's visiting hour restrictions.

(d) Illustrations of Intra-Group Goal Conflict Issues

- One hospice wants to be among the first to meet the NHO standards, but cannot accomplish this without jeopardizing its financial stability.
- In an effort to gain greater rapport with physicians, nurses spend so much of their time consulting with physicians that they neglect the needs of the patients and anger other team members.
- Social workers collectively become so concerned about the soon-to-be bereaved families that the needs of dying persons are neglected as efforts are focused on the families.
- Staff cliques develop within a hospice team -- a nurse clique, a social worker clique, a volunteer clique -- seriously reducing patient care quality.
- There is team dissension when hospice professional volunteers are not afforded the same privileges of paid staff.
- The hospice nurse is viewed with some distaste by the medical community. In an effort to restore good rapport with community physicians she supports the referring physician's recommendations in patient care meetings regardless of whether or not a more appropriate care modality could be defined, much to the displeasure of the other team members.
- Some of the nurses in a hospice feel they should give talks in the community in their spare time, while the rest of the nurses feel they should only give talks if they are paid for their time.

(e) Illustrations of Inter-Group Goal Conflict Issues

- Patient care teams become increasingly disillusioned with the hospice management team because it pushes staff members to see more patients than they feel capable of while still maintaining high quality hospice care.

- Patient care teams feel as though the hospice environment is too structured with policies and procedures to be "homelike" resulting in tension between the management group and the patient care team.
- One family resents the involvement of the hospice team because they called the hospice "not for themselves" but "for the benefit of the dying family member".

(f) Illustrations of Group-Organization Goal Conflict Issues

- To build community support, community leaders and media people are encouraged by the hospital to visit the hospice inpatient unit, but in so doing they disrupt the patient care process.
- A home health agency attempts to provide hospice home care during its regular working hours, five days a week. The resulting stress on families who have no source of support during the remaining hours and days of the week reduces the quality of hospice supportive care and may lead to unnecessary inpatient admissions.
- A nursing home wants its medical director to cover its hospice program to control costs but the hospice program wants to choose its own medical director who would have more knowledge, skill and time for patient care, at reasonable additional cost.
- A hospital goal of major research projects to expand its reputation hampers the hospice program's emphasis on the patients controlling their own care.
- To protect its future fund raising efforts, a major hospital consortium disallows its hospice program to initiate a much needed fundraising campaign of its own.

D. Approaches To Training: Goals

This section includes: background information for the trainer, three session outlines for interdisciplinary team training in goals - one in goal setting and the other two in goal prioritization and performance goal development, and examples from hospice training experience. The way the four goal issues (identified in Section C above) are addressed in the sessions are discussed.

1. BACKGROUND INFORMATION FOR TRAINERS

(a) Timing of Sessions on Goals

"Goals" should be the first topic in a team building program for the following reason. Since discussion of roles, structure, procedures and norms tend not to be productive without initial goal congruity, the group members to be trained need to agree on the goals of the organization (the hospice), and of the team, if different, and to tie in their individual personal goals with the organization's (and team's) goals. Only then can they address how best to reach these goals through their roles, structure, procedures and patient care activities.

However, as the training program is developed to meet the needs of each particular hospice group, flexibility is necessary in planning the program. Although it is recommended that the goal setting session begin the program, the prioritization and performance goal development may or may not be the topic of the second session.

> Example: In one hospice, the role conflicts between the patient care staff and the hospice administration were identified in the data collection to be of serious concern. It was the trainer's opinion that goal prioritization would be difficult to accomplish in such a charged atmosphere and that roles should be addressed as early as possible in the program. Therefore, goal prioritization was placed at a much later point in the program, in the belief that by that time the group would be ready and able to work together productively.

In this chapter, however, the second and third goal sessions follow the first.

Again, flexibility is needed to allot as much time as is needed by the particular hospice group - more than three session if necessary - to reach congruence on organizational goals and performance goals.

(b) Relationship of Training Sessions to Goal Issues

The four identified goal issues may be best covered in training sessions as follows:

- Goal Ambiguity/Clarity
  This issue arises in goal setting and is therefore part of the opening session. Additional confirmation continues through all sessions but particularly sessions 2 and 3.

- Goal Prioritization
  This issue is the main topic of the second goal session. It follows, either immediately or later on, after goals have been established.

- Goal Agreements/Contracting
  The development of performance goals and a timetable for accomplishing them is included in the second and third goal sessions. Additional sessions to complete this work and reach agreement may be necessary.

- Goal Conflict Identification/Management
  This issue may arise in any or all of the goal setting and goal prioritization sessions. Methods of goal conflict management may, in addition, arise during any session.

(c) Trainer Planning of Goal Training Sessions

Three training session outlines are provided in Section D.2., following. At the discretion of the trainer, in consideration of the size of the team and its needs, these three may be reduced to two or expanded to four.

For these three, the outlines are based on general time frame estimates as follows:

- The length of each session is three hours.
- Opening Remarks and Closing Remarks take up approximately ten to fifteen minutes each, depending on questions and responses.
- There is at least one break of approximately ten minutes.
- The balance of the time - from two to two and a half hours - is available for the presentations and exercises.
- The presentation in Session 1 is estimated at fifteen minutes. No other presentation during these three sessions should take more than a minute or two.
- The exercises and group discussions should be open yet controlled to fit the time available.

(d) Trainer Behavior in Opening Sessions

The following is a reminder of the major role behavior requirements of the trainer in the early sessions (see Monograph 2).

- Facilitate open discussion but keep participants pretty much on track.
- Avoid if possible direct open conflict between participants (until group is more comfortable together and with trainer).
- Ensure group understands trainer role, and behave so that group develops confidence in trainer and with the trainer's stated role.
- Encourage participation from all participants within their level of comfort. Do not permit supervisory members to dominate. Emphasize the equality of all members within these training sessions.

2. OUTLINE OF TRAINING: GOALS

The three proposed training sessions on goals (Training Program Sessions Nos. 1, 2 and 3) are outlined in this section under the following headings:

- Purposes of the Session.
- Preparation by the Participants for the Session.
- Preparation by the Trainer for the Session.
- A Model of the Session:
    - Opening Remarks
    - Presentation (if any)
    - Exercises
    - Closing Remarks (including session evaluation).

Session 1. Goal Setting: Definition, Clarification, and Congruity

Purposes of the Session:

- To provide an orientation to team building, and
- To develop an agreed upon list of goals.

Preparation by the Participants for the Session:

Several days prior to the session, ask each participant to prepare a list of hospice goals.

Preparation by the Trainer for the Session:

- Review sections of the series: Monograph 2, Chapter II; Monograph 3, Chapters II, V, VI, VII; Monograph 4, Chapter II.
- Use, if desired, the following recommended major written resources:
    - Rubin, I.M., Plovnick, M.S., Fry, R.E., *Improving the Coordination of Care: A Program for Health Team Development*, Cambridge, MA, Ballinger Publishing Company, 1975, (Introduction and Module 2)
    - Schein, E.H., "Intergroup Problems in Organizations", in *Organization Development: Theory, Practice and Research*, French, W.L., Bell, C.H. and Zawacki, R.A. (eds.), Business Publications, Inc., Dallas, 1978. pp. 80-84.

A Model of the Session

Opening Remarks

After the hospice director, or other hospice official, calls the meeting to order, introduces the trainer and any other non-team members in attendance (such as the recorder), and hands over the meeting to the trainer, the trainer should:

- Request team members to introduce themselves.
- Describe own role as facilitator. Identify role expectations for group. Identify person in charge and that person's role in the conduct of the training.
- Respond to any questions.
- Review the plan for all team training sessions and the obligations of the participants (i.e. homework, regular attendance, participation).
- Review the purpose and agenda and expected outcomes for the session and ask for agreement from group.
- Respond to any questions.

Presentation

- Present short statement concerning goals, the importance of goal clarity to team development, and the rationale for goal setting as a topic of the first session:
    - Goals: When the task to be performed requires a team, the goals are the reasons for existence of the organization, the tasks and the team.
    - Roles: Issues of coordination, what the team wants to do, must be defined as to who and how. Roles entail the assigning of responsibility for tasks or parts of tasks, and of the way they are to be carried out. Roles change when goals or tasks change.
    - Structure: The organization structure allows the team to function and determines its membership. The structure necessary to support an organization's functions is directly related to goals.
    - Procedures: Procedures coordinate how things get done, such as who makes decisions about what. Procedures are task related and are dependent upon goals and roles.
    - Because of the interrelatedness of all of the above, there is a need to begin at the beginning - with goals.

Exercises

- Request participants to share their lists of goals (prepared previously by each participant).

  (By preparing individual statements and sharing them with the group everyone will be aware of where there is agreement and disagreement).

- Assist participants to combine the individual goal statements into a master list on a flipchart or blackboard and to add any goals the participants feel were missed.

- Identify items that are not clear, are in conflict with one another, or need further discussion.

- Facilitate group discussions of the identified areas and modify blackboard/flipchart statements accordingly.

- Assist the group to develop either:

  - one major mission statement and a number of subgoals, (areas specifically identified as important to mission statement, or additional goals as corollaries to the major goal), or, if this is not possible,
  - simply a list of all the goals identified.

- Facilitate a group review of this statement or list to improve the wording and to ensure that all goals appear on this list.

- Request someone to volunteer (or have the group identify one of its members) to record this statement or list, have it typed and distributed to all participants for the next session.

- Note that goals may be added, subtracted, or modified by the group through time.

Closing Remarks

- Faciliate the group's evaluation of the session.

- Reconfirm next group meeting and topic for discussion.

- Assign reading or work for next session.

Session 2. Goal Prioritization and Performance Goal Development

Purposes of the Session:

- To prioritize the goals and sub-goals previously developed and agreed, and
- To develop performance goals (measurable objectives).

Preparation by the Participants for the Session:

There is no specific preparation recommended.

Preparation by the Trainer for the Session:

- Use, if desired, the following recommended written resources:
  - Rubin, I.M., Plovnick, M.S., Fry, R.E., Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Company, 1975, (Introduction and Module 2)
  - Wise, H., Beckhard, R., Rubin, I., and Kyte, A.L., Making Teams Work, Cambridge, MA, Ballinger Publishing Company, 1974.

A Model of the Session

Opening Remarks

- Review the purpose, agenda and expected outcomes for this session and ask for agreement from the group.
- Review the mission statement and goals previously developed and ask for confirmation or agreement.

  (Flipchart/blackboard list of goals is on display, and typed copies of this list have been distributed.)
- Respond to any questions.

Exercise No. 1

- Ask the group to study each item of the mission statement and/or list of goals in terms of its relative importance, and to:
    - Rate each item "high", "medium", or "low" according to its priority (organizational, not individual, priority) at the present time. Includes prioritization review in terms of the short term and long term aspects of each goal, and, after all goals have been prioritized,
    - Operationalize each goal by establishing quantitative performance measures and time frames for achievement.

- Facilitate the group consensus of the rating for each goal in a very task-oriented fashion.

- When all goals have been rated, have the group review them to see if there are any changes. (There should be a mix of highs, mediums, and lows.)

Exercise No. 2

- Facilitate the discussion of quantifying prioritized goals. The group is to create performance goals to measure whether the core mission statement is being achieved. Four decisions need to be made in order to create a performance goal:
    - the exact meaning of the goal statement,
    - the amount of the goal to be accomplished,
    - the dates by which the sub-goals are to be done, and
    - the realistic percentage of each goal that can be accomplished within a reasonable length of time (say, two years).

- Present to the group alternative methods of the conduct of the exercise:
    - group remains convened; everyone quantifies each goal (very time consuming if the group has more than six members),
    - subgroups (2-3) convene; each group reports back to the entire group after specified time (depends on time available and size of group),
    - each individual quantities a goal; entire group reviews (depends upon size of group), or
    - executive director quantifies all goals; presents proposal to entire group (not desirable; strive for continued group process).

- Facilitate a group decision, based on the size of the group, the session time available, and the number of goals to be quantified. Establish a time frame for completion of the exercise.
- Respond to any questions.
- Assist the group in getting the exercise underway in the agreed format. Ensure the performance goals generated are recorded.
- If group members have been broken into subgroups or have worked individually, reconvene them when the allotted time has passed.
- Facilitate group overview of the wording of performance goals, elimination of duplications, and the preparation of a first draft of all performance goals, including sub-goals and associated due dates.
- (If time is short and/or other options are chosen, end the session and request that the rest of the exercise be performed as homework.)

Closing Remarks

- Facilitate the group's evaluation of the session and the skills utilized in the exercises.
- Assure participants that discussion of performance goals will occur in the next session.
- Assign reading or work for the next session.

Session 3. Performance Goal Prioritization and Action Plan Development

Purposes of the Session:

- To finalize performance goals,
- To prioritize performance goals, and
- To gain consensus and support for reaching performance goals within specified time frame.

Preparation by the Participants for the Session:

Depending on the exercise option chosen by the participants in Session 2, homework consists of preparing or reviewing performance goals and action plans.

Preparation by Trainer for the Session

- Review, if desired, the following major reference materials:
  - Rubin, I.M., Plovnick, M.S., Fry, R.E., Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Company, 1975, (Introduction and Module 2).
  - Ducanis, A.J., and Golin, A.K., "Improving Team Performance", The Interdisciplinary Health Care Team, Germantown, MD, Aspen Systems Corp., 1979, pp. 167-182.

A Model of the Session

Opening Remarks

- Review the purpose of the session and obtain group agreement.
- Respond to any questions.

(Flipchart/blackboard lists of performance goals, if developed in the previous session, are on display. If these were developed as homework, typed sheets of performance goals are distributed.)

Exercise

- Facilitate a group discussion of each of the performance goals. Clarify, restate, and finalize agreement of the group on decisions, actions and due dates. Ensure that all items are completely understandable and measurable in the final format.

- Complete (or ensure that group completes) final list of prioritized performance goals with associated due dates.

Closing Remarks

- Urge the group to review the performance goal list periodically:
  - Entire group should participate in formal review every 4-6 months of actual status in relation to plan, and initiate actions to meet agreed goals.
  - Group may consider the formal structuring of the performance goals by the use of a milestone chart or comparable timetable by which to display those goals which have been met and those which require further attention.

- Facilitate the group's evaluation of the session.

- Reconfirm the topic for the next session.

- Assign reading or work for the next session.

3. EXAMPLES FROM HOSPICE TRAINING EXPERIENCE: GOALS

The following examples provide a flavor of the training but do not necessarily have applications in all settings. Each hospice site requires specific training to meet its own needs and goals. The inclusion of the examples in this section is not intended in any way to direct or limit the development of the trainer's and the hospice team's own materials. Examples (a) and (b) are not verbatim transcripts but are sufficiently accurate to convey the session's content.

(a) Example of Statement of the Role of the Trainer

The following is the report of the trainer's remarks concerning his role, made at an opening training session.

> My role with you in these meetings is to facilitate and to suggest approaches and techniques for generating information, but the decisions to be made have to be made by you. I will do nothing but facilitate except for a couple of occasions when I will provide some didactic material - like today I will be talking for about fifteen minutes on teams and later again or organization structures. Otherwise, however, I will not lecture. I would like you to be as open as you can in all these sessions. This is a safe environment to do so -- to be open and honest, but there are bosses here and decisions are not necessarily made by the entire group.
>
> There are a few ground rules. The issues discussed here are confidential to this group. Work on problems in the sessions only initially. Responses should be open and honest However, if any aspect of the session is brought up outside don't say anything there that you don't feel you can talk about here. If this practice isn't exercised then decisions made here won't be as good as they could be. Team building is not intended to be reserved for these sessions. Aside from problems, you should talk to each other during the week about the sessions. Later during the sessions there may be directions to do some exercises outside of the group.

(b) Example of a Short Lecture on Goals

This introductory lecture on team goals was presented by the trainer from the perspective of his activities in research and writing.

Ten years ago several colleagues and I worked in neighborhood health centers and other health settings to gather data for a book. Through our work we identified four major areas related to teams:

- Intrapersonal - personality, style (the most frequently mentioned).
- Procedures - communications and decision making (the coordinating mechanisms).
- Roles - ambiguity: individuals are confused about what is expected of them and what other people are doing, and
  - conflict: individuals are knowledgeable about what other people are doing or what is expected of them but disagree.

  Both ambiguity and conflict make it difficult for people to work with each other and create stress and turnover.
- Goals - ambiguity: of the organization and of the team, and
  - conflict: disagreements

  (least frequently mentioned).

Our approach, then, was to focus on intrapersonal styles with sensitivity training and encounter groups. This was quite unsuccessful. The T-group had little or no effect on organization, efficiency or improvement. Issues were not resolved. We redefined the areas then to procedures, roles and goals. This was less of a problem as it attributed these areas to other people; it was not an attempt to change a person but to change the meaning of the work - the context. We ended up ordering the topic areas just the reverse of the frequency that they were first mentioned - goals, roles, procedures and intrapersonal styles.

Conceptually, we ask what is the team existing for? It exists because a task is required. The team is a product of the task. There are issues of coordination - what the team wants to do - that must be defined as to who and how. One can then assign responsibility for tasks which involves roles;

roles change when goals change. For procedures, we talk about coordinating - but coordinating what? You need to know who makes decisions to coordinate. All this depends on roles and goals so the interpersonal and intrapersonal problems disappear. It becomes a task related issue, not an issue of personalities. We can't do much directly with intrapersonal problems in team training. If there are real intrapersonal problems, the possibilities are:

- To separate the people that have the problems,
- To communicate by paper, or
- To have the people find a position elsewhere.

If everyone can buy into the goals, then the interpersonal and intrapersonal problems diminish.

After our initial analysis we added another category - structure, which is the system which allows the team to function. Sometimes the coordination is more important than functional relationships. Frank Lloyd Wright said "form follows function" which interprets into our work here as "structure follows goals".

(c) Example of Mission Statement and Sub-Goals

The following document was developed by the home care team being trained. The goals were written, modified, and remodified until all members fully agreed with this final form.

GOALS OF THE HOSPICE

Mission:

To provide the best available knowledge, support and skill in the areas of physical, social, emotional and spiritual care to terminally ill patients and families, before, and for the family, after the death, within the range of acceptance and capability of the patient/family, and within the resource constraints of the hospice.

Additional goals:

1. To provide a complete hospice program which includes home care, inpatient beds and a bereavement program.

2. To seek National Hospice Organization certification.
3. To deliver hospice care with an interdisciplinary team approach.
4. To maintain financial viability.
5. To provide education regarding hospice to patients, families, health care professionals, other agencies and the community at large.
6. To promote hospice by remaining viable in the community.
7. To provide for staff support system.
8. To encourage continuing education and provide in-service education for staff.
9. To develop an educational center.
10. To conduct research in the area of hospice care.

(d) Example of a Performance Goal

The example that follows is a performance goal statement for Goal #8 in the list in (c) above.

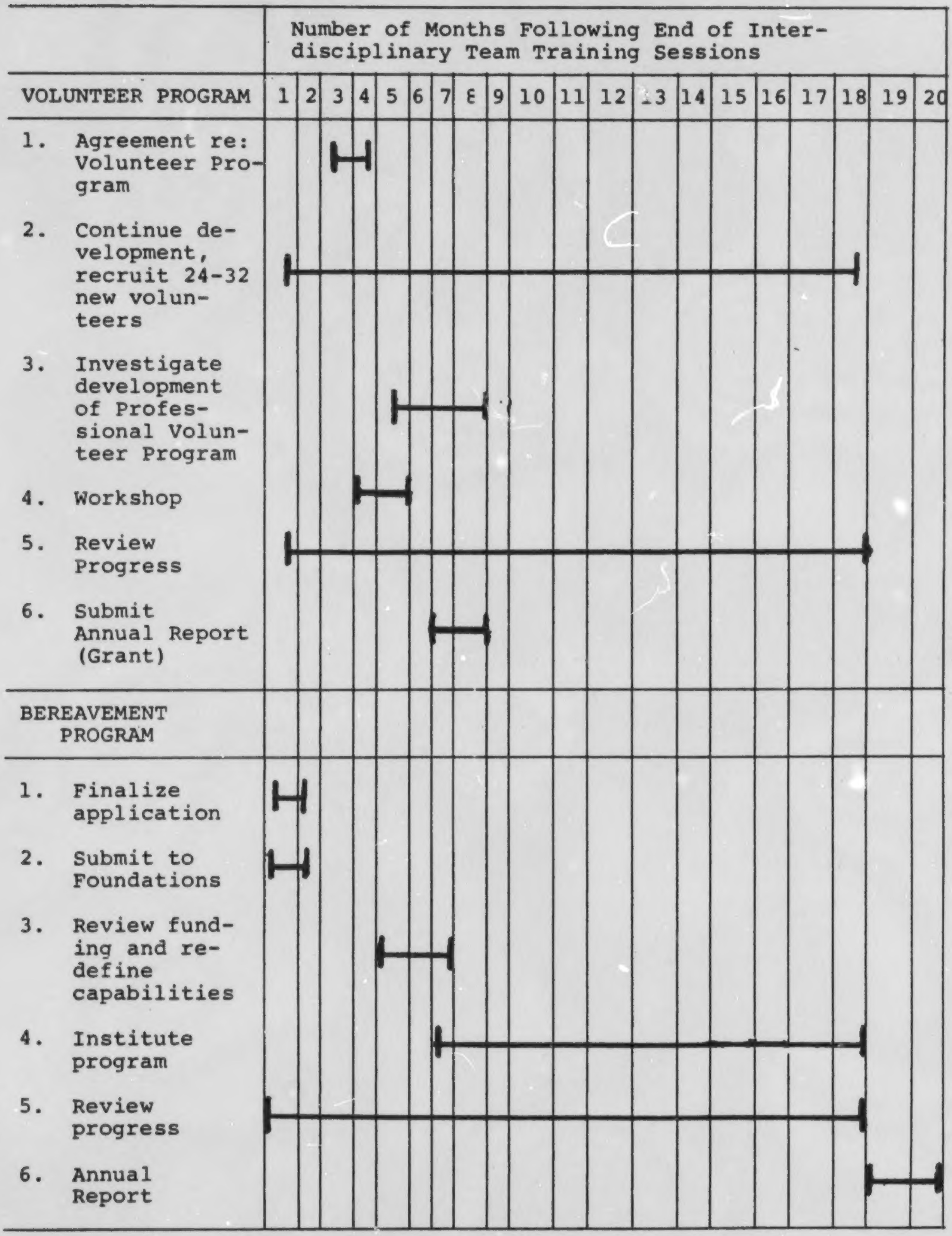
GOAL: ENCOURAGE CONTINUING EDUCATION AND PROVIDE IN-SERVICE EDUCATION FOR STAFF

	DUE DATE
• Encourage continuing education:	
•• Hospice provides staff with current CE (Continuing Education) information by posting on bulletin board each month.	Monthly
•• Each staff member attends at least one CE activity per year at own expense, with leave of absence.	Yearly
•• Hospice provides format for each staff member to report education at least one time per year at case conference.	Yearly
•• Beginning in June 1983, hospice provides each staff member five days CE time per year for CE of each individual staff member's choice, or the amount of time per year provided by other health care institutions/agencies in the community.	6/83

- Provide in-service education for staff:
  - Provide in-service time, within the financial constraints of the hospice, and/or written accreditation requirement, or one hour per month, within six months. 1/81
  - Prepare a questionnaire, circulate it to staff, and collect information back concerning desired in-service topics by October 1980. 10/80
  - Compile and analyze staff supplied information in November; coordinate staff and administration needs and desires. 11/80
  - By December, 1980, develop tentative six-months' schedule for in-service; determine availability of professional and lay teaching resources. 12/80
  - In January 1981 implement in-service schedule. 1/81

(e) Example of a Milestone Chart

The following is part of a milestone chart or time line for performance goals, developed by a hospice during interdisciplinary team training.



E. SELECTED REFERENCES FOR TRAINING: GOALS

Selected reading materials on the subject of goals are listed in this section for use by both trainers and participants. It is not intended that these materials be indicative of an exhaustive search on goals relating to hospice or hospice staff. Rather, the following citations, both generic to organization development and specific to health care groups, are intended to provide the reader with an awareness of goal issues which have an impact on the functioning of a team (group) and the development of an organization.

Reading materials are compiled alphabetically. When particularly applicable to one or more of the four identified goal issues, the item is coded at the conclusion of the citation as follows:

(1) = Goal Ambiguity/Clarity Issue
(2) = Goal Prioritization Issue
(3) = Goal Agreements/Contracting Issue
(4) = Goal Conflict Identification/Management Issue

Beckhard, R., "Organization Issues in the Team Delivery of Comprehensive Health Care", Milbank Memorial Fund Quarterly, 50, July 1972, pp. 287-316. (1)

Ducanis, A.M., and Golin, A.K., "Team Goals and Activities", in The Interdisciplinary Health Care Team, Germantown, Maryland, Aspen Systems Corporation, 1979, pp. 89-118. (1) (2)

Ducanis, A.M., and Golin, A.K., "Improving Team Performance", in The Interdisciplinary Health Care Team, Germantown, Maryland, Aspen Systems Corporation, 1979, pp. 167-182. (2)(4)

Dyer, W.G., Team Building: Issues and Alternatives, Reading, MA, Addison-Wesley, 1977.

Holm, A.A., "Team Issues", in Early Intervention: A Team Approach, Allen, K., Holm, A.A., and Schiefelbusch, R., (eds.), Baltimore, University Park Press, 1978, pp. 99-115. (1)(4)

Perrow, C., "Goals and Power Structure", in The Hospital in Modern Society, Freidson, E. (ed.), New York, Free Press, 1963. (4)

Rubin, I.M., Plovnick, M.S., and Fry, R.E., "A Team Trying To Do What? - Goal Setting", in Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Company, 1975, pp. 55-76. (1)(3)

Rubin, I.M., Plovnick, M.S., and Fry, R.E., "A Team Trying To Do What? - Setting Priorities", in Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Company, 1975, pp. 77-94. (1)(2)(3)

Schein, E.H., "Intergroup Problems in Organizations", in Organization Development: Theory Practice and Research, French, W.L., Bell, C.H., and Zawacki, R.A. (eds.), Dallas, Business Publications, Inc., 1978, pp. 80-84. (1)

Vogt, M., and Ducanis, A.J., "Conflict and Cooperation in the Allied Health Professions", Journal of Allied Health, 6:1, 1977, pp. 23-30. (2)(4)

Weisbard, M.R., Diagnosing Your Organization, Wynnewood, PA, Organization Research and Development, 1976.

Wise, H., Beckhard, R., Rubin, I., and Kyte, A., Making Health Teams Work, Cambridge, MA, Ballinger Publishing Company, 1974.

CHAPTER III

TRAINING CATEGORY 2: ROLES

A. Introduction

Chapter II described methods to reach team congruence on what the team exists to do - its goals. In order to accomplish these goals, all team members need to understand what their jobs are - their roles - and need to be able to perform them efficiently. In team function the term "role" is distinguished from the term "job description" in that roles may change frequently depending on the nature of the task to be performed, and from time to time may exclude or reduce some activities specified in the formal job description or may include some activities additional to it.

Ducanis and Golin* add,

> Although teams differ in the extent to which roles overlap and conflict, in the clarity of the role definitions, and in the flexibility of established roles, role definition and differentiation are team characteristics. A group in which each person can and does fill all roles is not a team.

However, the very nature of hospice requires timely and responsive support by the person or persons to whom the patient and family relate best (regardless of profession or job description).

This "role blurring" or "role blending" appears to conflict with Ducanis and Golin but, in fact, is consistent when this facet of the role is clearly understood by team members. Teamwork, according to Webster's Third New International Dictionary** includes each team member "usually doing a clearly defined portion (of the work) but all subordinating personal prominence to the efficiency of the whole". In a hospice team, not only personal prominence but also disciplinary predominance is subordinated to the efficient and effective accomplishment of team goals.

Training in roles is conducted through facilitation. It does not attempt to define hospice team member roles, but rather presents skills and methods for team members to define and clarify their own roles and then to modify them as the tasks to be performed change through time and from patient to patient. This chapter describes this method, and provides examples of roles and issues frequently found in hospices, in order to familiarize trainers with the hospice environment.

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* Ducanis, A.J., and Golin, A.K., The Interdisciplinary Health Care Team, Germantown, MD, Aspen Systems, 1979, p. 6.

** Webster's Third New International Dictionary, unabridged, Springfield, MA, G. and C. Merriam Company, 1976.

This chapter addresses the topic of roles under the following headings:

- Hospice Specific Examples: Roles
- Issues in Training: Roles
- Approaches to Training: Roles
    - Background Information for Trainers
    - Outline of Training

        Session 4. Role Negotiation

        Session 5. Role Definition and Renegotiation
    - Examples from Hospice Training Experience
- Selected References for Training: Roles

B. Hospice Specific Examples: Roles

Hospice experience has enabled the identification of individual role statements of hospice patients and their caregivers. Group statements relating to roles - or "role areas" - have been identified for families, patient care teams, and hospice organizational representatives (management teams). Examples of these roles and role areas follow, Exhibits 9-13, to acquaint the trainer with the role ambiguities and conflicts common to hospices. No value judgments are placed on these examples of roles.

EXHIBIT 9

Examples of Patient Roles

- to communicate verbally and non-verbally to hospice team, own physical, emotional, social and spiritual needs
- to be responsible for feedback to family and staff about the kind of care being rendered
- to act as the educator of the staff in improving care to terminally ill persons
- to be the director of care provided
- to be the creator of a plan to come to terms with the situation for both self and family
- to take responsibility for the completion of any remaining "unfinished business"

EXHIBIT 10

Examples of Caregiver (Individual Team Member) Roles

- to direct the patient's medical care (primary physician and/or medical director)
- to increase range of motion and activity within the patient's capability (physical therapist/occupational therapist)
- to reduce the patient's painful activity and exercise to ensure comfort (nurse)
- to provide all relevant information on patient's medical history and prognosis in writing (referring physician)
- to make the ultimate decision on the admission of a patient to the hospice program (medical director)
- to screen volunteers carefully and match them to patients/families (volunteer director)
- to teach primary physicians new approaches to pain and symptom control (medical director)
- to massage the skin to prevent breakdown (physical therapist)
- to provide sacraments to patients (chaplain)
- to reduce anxiety of patients regarding inability to pay for services (social worker)
- to provide drug regiments to control distressing phsyiological symptoms (clinical pharmacologist/physician)
- to direct and coordinate staff in the conduct of patient care activities (head nurse/home care coordinator)
- to find and supply the food the patient wants, regardless of the difficulties involved (nutritionist)
- to be responsible for maintaining the financial viability of the hospice program (administrator)

EXHIBIT 11

Examples of Role Areas of the Family

- to support the patient in a way defined by the patient or by hospice staff
- to act as an advocate on behalf of the patient when appropriate
- to participate as a member of the care team to whatever degree possible when this is concommitant with the desires of the patient
- to assist in the articulation of patient needs when the patient is unable to do so and desires such assistance
- to perform all care activities for the patient (except administration of medications) even when patient is an inpatient
- to take care of all the patient's personal business matters

EXHIBIT 12

Examples of Role Areas of the Patient Care Team

- to provide psychosocial and spiritual support to patient and family
- to provide bereavement support to family
- to be on call to patients 24 hours a day, 7 days a week
- to make recommendations to primary physicians regarding modalities of treatment and care plan revisions
- to attend scheduled patient care review meetings
- to assist in the management of the patient's total pain
- to work with the patient and family as the unit of care
- to facilitate the active participation of both the patient and family in the care planning and care provision
- to make decisions regarding the most appropriate care modality
- to work together to develop internal mechanisms to support the team

EXHIBIT 13

Examples of Role Areas of Organizational Representatives (the Management Team)

- to provide educational programs in the community, when requested and appropriate
- to maintain an organizational structure which facilitates the hospice concept
- to sustain the operation of the hospice through obtaining both maximum reimbursement and foundation funds
- to develop and conduct research on the economic feasibility of hospice
- to assist the patient care team in negotiating with community resources to provide needed services to patients and families
- to encourage families to request memorial donations to the hospice

C. Issues in Training: Roles

Clearly, the examples of roles and role areas point up not only the conventional role issues of ambiguity and conflict but also the issue essential to hospice but seen less frequently elsewhere of role blurring. These issues need to be resolved for teams to be interdependent enough to deliver coordinated high quality hospice care with minimum stress and maximum efficiency.

When interdisciplinary team members share common goals, they also share the right and responsibility to understand clearly and agree to their own and each other's roles. However,

- Role ambiguity may occur when team members are not sure what they should be doing, what the expectations of other team members are, or what other team members should be doing. If roles are unclear, skill training in role negotiation will help team members to clarify these ambiguities.

- Role conflict may occur when team members' expectations of each other's roles are not consistent, such as when one team member's understanding of his or her role does not agree with that of the other members of the team, or when some team members' expectations differ from (conflict with) other team members' expectations of the role of one of the team members. A situation in which a team member has too large a role or too many roles to be able to accomplish the work required is also designated role conflict. Role conflict can be resolved through conflict identification and role negotiation procedures.

Roles, then, when identified, may be unclear, in conflict with other roles of the same person, in conflict with the expectations of all or parts of the rest of the team, or in conflict because of overload.

The following role issues have been identified:

- Role Ambiguity/Clarity
- Role Conflict/Resolution
- Role Blurring

The relationships of role issues to individual roles and group role areas, for the categories described in Section B, above, are displayed graphically in Exhibit 14, following.

EXHIBIT 14

Relationships of Role Issues to Roles and Role Areas

PROCESS ISSUES	ROLES		ROLE AREAS		
	Patients	Individual Team Members (Caregivers)	Family	Team	Management Team (Organization)
ROLE AMBIGUITY/ CLARITY					
ROLE CONFLICT/ RESOLUTION					
ROLE BLURRING					

Illustrations of these roles as they apply to hospice situations are described below under the following headings:

- Illustrations of Role Ambiguity/Clarity Issues in Hospices:
  - Individuals
  - Teams
  - Organizations
- Illustrations of Role Conflict/Resolution Issues in Hospices:
  - Between Individuals
  - Between an Individual and a Group
  - Within a Group
  - Between Groups
  - Between a Group and an Organization
- Illustrations of Role Blurring Issues in Hospices.

1. ILLUSTRATIONS OF ROLE AMBIGUITY/CLARITY ISSUES IN HOSPICE

PROCESS ISSUES	ROLES		ROLE AREAS		
	Patients	Individual Team Members (Caregivers)	Family	Team	Management Team (Organization)
ROLE AMBIGUITY/ CLARITY	(a)	(a)		(b)	(c)

(a) Ambiguity Issues - Individuals

- Some hospice staff members defined "acting only for the comfort of the patient" to mean not turning or moving the patient if in so doing the patient experienced short-term discomfort. The resulting bed sores and reduced range of motion for the patients required an immediate clarification of definitions and functions.
- Team meetings are difficult for a hospice physician as he doesn't know whether he should discuss his opinion of the patient care plans with the other members or merely listen to their views and make his own decision later on.
- Having been sick for some time and accustomed to the role of the "good", complacent patient in the traditional health care setting, a patient is having difficulty with the hospice team continually asking his opinion about his care.
- When team members share with a patient that they want to learn from her, the patient becomes fearful of the new responsibility to teach others.
- A social worker isn't sure if she is to spend all her time with hospice patients or to spend part of her time visiting cancer patients in the oncology unit who will eventually become hospice patients.
- A home care coordinator, with staff scheduling decisions to make, is unsure whether or not she should approach some of the regular hospice referring physicians to see what patients are expected to be referred soon.

(b) Ambiguity Issues - Teams

- Recognizing that their caring efforts are to be directed to both patient and family, one hospice team is unsure of the balance to be drawn between who gets more of the team's attention.

- Differences in interpretation among team members of the term "psychosocial needs" create confusion as to what their tasks are in meeting these needs.

- With an increasing patient load, one hospice team ceases seeing bereaved families because its members interpret their major role as supporting the dying patients.

- Several hospice teams are unsure of how to incorporate the patient and family as participating members of the care team.

- Other hospice teams are unsure of how to interface with patient and family when they are incorporated as a part of the care team.

(c) Ambiguity Issues - Organizations

- Once research has been conducted to measure the economic feasibility of hospice care the hospice administrator is unclear about how to improve the economic status of the hospice without jeopardizing its quality of care.

- One hospice is struggling to learn what its responsibility is within the community and is receiving mixed messages from community leaders.

- Several hospices feel uncomfortable accepting donations from church groups because they are not sure what commitments are expected of them by these groups.

- With the multitude of roles that hospice management must play, there is sometimes confusion about how to find the time to accomplish all of them.

2. Illustrations of Role Conflict/Resolution Issues in Hospices

PROCESS ISSUES	ROLES		ROLE AREAS		
	Patients	Individual Team Members (Caregivers)	Family	Team	Management Team (Organization)
ROLE CONFLICT/ RESOLUTION	✓	✓	✓	✓	✓

(a) Conflict Issues - Between Individuals

- A nursing supervisor doesn't want to upset a nurse by telling her that a patient, to whom she was attached, died while she was off duty, but the nurse, on discovering the death, is upset that the supervisor did not advise her and support her through this period.
- Having had an argument with the patient, a family member is prepared to step aside as caregiver (as angrily requested by the patient) and hire a full time nurse to care for the patient.
- One hospice patient views herself as being in charge of her care, but her principal care provider - her twin sister - views that same role as being her own.
- One hospice patient is a social worker by profession. She finds herself competing for the role of social worker with the hospice team social worker.

(b) Conflict Issues - Between an Individual and a Group

- After a falling out with the family, a patient instructs the hospice team not to speak with any member of the family in person or on the phone without the prior approval of the patient.
- A patient being maintained at home is becoming increasingly debilitated requiring the full time attention of the family. The family is physically and emotionally distressed and finally requests the hospice team to admit the patient to the inpatient facility temporarily. The patient is outraged at their action and rejects both family and care team.
- A physician feels his role in supporting staff is to give each one a big bear-hug, which some staff members find painful and others are upset because their coiffures are in disarray.
- A medical director is excluded from real team membership by the rest of the staff, resulting in considerable stress.
- Another medical director is more interested in teaching medical students than in supervising detailed patient care, with resulting reduction in patient care quality and distress on the part of the staff.

(c) Conflict Issues - Within a Group

- A heated argument develops between family members and the hospice team when the nurse recommends a brief inpatient admission to bring the patient's symptoms under control. The family insists the care can be provided in the home and the patient, yielding to the authority of the family, agrees to stay home despite extreme discomfort.
- Every weekend hospice home care nurses are on call in rotation. A review of attendance records indicates that one particular nurse has phoned in sick three out of eight times when scheduled to be on call. Other team members resent the inconvenience of the rescheduled assignments.
- A social worker is upset and antagonistic toward other hospice team members because the nurses are doing counseling which he feels should be his role only.
- The chaplain assumes the role of advising patients that the reason for their illness, suffering and dying, is "God's will", which increases the stress level of both other staff members and the patients concerned.

(d) Conflict Issues - Between Groups

- Several members of one patient care team are having difficulty integrating the patient and family into the care team. The patient is reportedly "incorrigible" and the family "helpless", with the result that the team makes care decisions unilaterally, regardless of the expressed wishes of patient and family.
- Hospice management teams feel it is their responsibility to create personnel policies but the patient care teams feel such policies should not be finalized without their participation.
- A bereavement support group, which initially began through the hospice care team, views its function as supporting recently bereaved persons. This is difficult for hospice nurses who have been making the initial visits to the homes of the recently bereaved persons and consider this their responsibility.
- A hospice home care team visits home care hospice patients who have been admitted to hospitals. Inpatient nurses complain that home care nurses are usurping their place in providing inpatient nursing care.

(e) Conflict Issues - Between a Group and an Organization

- One hospice is putting pressure on its patient care team to make more home visits. However, the team members relate that they are having difficulties functioning effectively as a team and request some time for their own internal development and exploration of the role of the team.

- An evolving hospice group in a town of about 500,000 receives "bad press" because a volunteer agency (in town for about two years prior to the development of the hospice) claims that it is already providing hospice-type services.

- One hospice patient care team is requested to speak before a large community group about hospice care. When the hospice management is advised, some of its members feel it would be more appropriate for them to speak. Both feel it is their responsibility and role to address the group.

3. Illustrations of Role Blurring in Hospices

PROCESS ISSUES	ROLES		ROLE AREAS		
	Patients	Individual Team Members (Care-givers)	Family	Team	Management Team (Organization)
ROLE BLURRING	✓	✓		✓	

- In one hospice, nurses have become so versed in social work functions that the team social worker is not required to visit patient's homes routinely, freeing her time for more demanding cases.

- The use of lay volunteers is encouraged to hold down the cost of hospice care and these volunteers in several hospices are used in the same capacity a social worker would be. This can work successfully because the social worker is available continually to the volunteers for consultation.

- One hospice patient very familiar with hospitals and their presenting staff, became uncomfortable when one volunteer, who had no formal social work training, presented herself as if she were an institutional social worker.

- Several young hospice nurses, familiar with working on hospital teams, are uncomfortable performing functions beyond their experience and education.
- One physical therapist on a home care team became so accustomed to having the nurses perform some of the ambulation exercises on patients that she neglected to conduct her own routine patient exercise program.

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D. APPROACHES TO TRAINING: ROLES

Training of interdisciplinary teams in the subject of roles involves experiential learning by the team members in role negotiation. This section addresses role negotiation in three ways: background information for trainers, training session outlines for two proposed sessions in role negotiation, and some examples from training experience in hospices. This review of training methodology with particular reference to its applicability to hospice environments is intended to prepare trainers for role training of hospice teams.

1. BACKGROUND INFORMATION FOR TRAINERS

(a) Timing of Sessions on Roles

The experienced trainer is the best judge of the timing of sessions. From ELM's hospice training experience it was found that the training topic of roles was best presented after goal congruity has been reached, since roles contributed to attaining goals. Role training, however, need not follow immediately after goal training, although it follows directly in this document. The particular needs of the team being trained may require the postponement of the role sessions until after other issues that may need to be resolved first are addressed.

For example, in one hospice, structural changes in the team itself were being considered and the trainer saw that role negotiation would be most helpful to team members when roles could be approached in terms of the modified team structure. The role sessions were therefore conducted only after "structure" sessions addressed the proposed team structure modifications.

Alternatively, considering the interpersonal relationships within the team, the trainer may decide that role negotiation is too threatening to address at this point in the training program, and may postpone it until other, less threatening topics are covered. Experiential learning in role negotiation often tends to be uncomfortable for team members. They must write and discuss openly the problems they are encountering and their lack of understanding of their job or the jobs of others, and they must negotiate verbally with another team member in front of the group. Team members need to be open, honest and specific in this process. If serious role conflicts within the team being trained were identified in the data collection process, the trainer needs to consider when in the training program these tensions are likely to be sufficiently eased for role negotiation to take place without serious discomfort or, alternatively, when real confrontation of these conflicts can safely take place. Role negotiation is intended to be problem solving and non-threatening. In one hospice, an extreme example of role conflict was identified. The problem was so intense that the trainer did not agree to begin the training until special sessions were conducted with those concerned to resolve this conflict. This is an unusual example; in most cases, the rapport built within the group over the first few sessions, with the facilitation of the trainer, soon enables the members to feel sufficiently comfortable to face the challenges of role negotiation.

(b) Alternatives for Role Negotiation Training

The methodology presented in the session outlined in Section 2, following, is based on that of Rubin, Plovnick and Fry*, in which two participants negotiate an individual role message sent by one of the participants to the other, with the remainder of the group acting as observers and, following the negotiation, as discussion participants.

Another methodology, described by Sherwood and Glidewell**, considers the negotiation to be two-sided, with the two participants exchanging role messages and bargaining with each other on a quid pro quo basis ("What are you willing to give to get what you want?"). The anticipated result is that the total amount of influence of the team members on each other should increase.

In both methodologies, messages are not considered adequately communicated until they are written down. Following negotiation and agreement, the "contract" between (or among) team members is written down, signed by those concerned, and a date set for the review and, if necessary, renegotiation of the "contract". Some antagonism to writing these messages and contracts may be anticipated. Trainers need to insist on this written communication for purposes of both verification and commitment to behavioral change, at least for some time. When participants feel clear about their own and each others' roles and feel skilled in the process of role negotiation and contracting, they may dispense with written role messages, but would be wise to continue committing the final contract to writing.

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* Rubin, I.M., Plovnick, M.S. and Fry, R.E., Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Company, 1975.

**Sherwood, J. and Glidewell, J., "Planned Renegotiation: A Norm-Setting OD Intervention", and Harrison, R., "Role Negotiation: A Tough-Minded Approach to Team Development", in Bennis, et al (editors); Interpersonal Dynamics, Third Edition, New York, Dorsey Press, 1973.

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(c) Relationship of Training Sessions to Role Issues

Since both role ambiguity and role conflict can be resolved through role negotiation, the first two issues are addressed throughout the sessions outlined:

- Role Ambiguity/Clarity Issues
- Role Conflict/Resolution Issues

Role blurring - the third identified role issue - needs to be addressed in the discussion of clarity. When role blurring is recognized clearly as a role function for all team members, issues in role blurring can be addressed.

(d) Trainer Planning of Role Training Sessions

Two training sessions on roles are anticipated. However, if the size of the group being trained is very small, one session may suffice. The time frame for completion of the work is estimated for a group of, say, ten to fifteen. For a larger group, tight scheduling may be necessary to permit all members to have their turns at negotiation.

Each trainer will need to schedule the time frames for the sessions in terms of the size and needs of the group. Rough estimates based on hospice training experience indicate that for a three-hour training session: fifteen minutes each should be allocated to opening remarks and closing remarks (including session evaluation); the first session presentation should be no longer than fifteen minutes; there should be at least one break of approximately ten minutes, and that exercises comprise the remaining time.

(e) Trainer Behavior in Role Training Sessions

The behavior of the trainer in role training has a major impact on the success of the sessions. Although Monograph 2, Chapter IV discusses the role of the trainer throughout the sessions, the behavior needed here is summarized below as a reminder:

- Be prepared to deal with participant reluctance to negotiate openly. Encourage the more confident members to demonstrate the method first, but be matter-of-fact about all members taking their turns. (Do not leave an opening for any team member to back out of participation or to dwell on reasons for doing so).
- Ensure that role negotiation proceeds in a non-threatening, task-oriented manner, with the purpose of the exercise being the accomplishment of the agreed-on goals of the team.

- Facilitate the role negotiations by keeping the negotiators focused on the problems and moving smoothly toward a solution.

- Keep up the pace of the individual negotiations. Do not allow the group to be bogged down in attempting to solve any one role problem. (Have them arrange a time outside of the team training session to discuss complicated problems.)

- Be prepared, however, for one or more role messages to raise significant and sensitive issues. (If none are raised, it may be wise to ask if they are being avoided). Such issues may need to be dealt with immediately, rather than postponed to another time.

- Be generally supportive of all group members throughout the process and share in their joy of accomplishment when they have all completed the assignments.

- Do not permit supervisory members to dominate or to participate outside of their "turns", such as offering to supply answers, directions or rules.

2. OUTLINE OF TRAINING: ROLES

The two proposed role negotiation training sessions (Training Program Sessions Nos. 4 and 5) are outlined in this section under the following headings:

- Purposes of the Session.
- Preparation by the Participants for the Session.
- Preparation by the Trainer for the Session.
- A model of the Session:
  - Opening Remarks
  - Presentation (if any)
  - Exercises
  - Closing Remarks (including session evaluation).

Session 4. Role Negotiation

Purposes of the Session:

- To learn and practice a method of clarifying roles and resolving role conflicts, and
- To negotiate ambiguities and conflicts in role messages initiated by hospice team members.

Preparation by the Participants for the Session:

Request participants at the previous session to read specified information on roles, and to prepare a role message for each of the participants, describing role expectations of them, to be read aloud in the session.

Preparation by the Trainer for the Session:

- Review sections of the series: Monograph 2, Chapter II; Monograph 3, Chapters II, V, VI, VII; Monograph 4, Chapter III.
- Utilize recommended major written resources, if desired:
  - Harrison, R., "Role Negotiation: A Tough Minded Approach to Team Development", in Bennis et al (eds.), Interpersonal Dynamics, third edition, New York, Dorsey Press, 1973.
  - Love, J.I. and Herranen, M., "Conflict in Teamwork: Understanding Roles and Relationships", Social Work in Health Care, 3:3, Spring 1978, pp. 323-330.

    - Mellette, S.J., "Interdisciplinary Teams in the Home Care of the Cancer Patient", in Kutscher, A. and Kutscher, L. (eds.), *Proceedings of the Foundation of Thanatology, Home Health Care and Quality of Life*, New York, Columbia Presbyterian Medical Center, April 1976.
    - Reynolds, D.K., "Work Roles in Death-Related Occupations", *Journal of Vocational Behavior*, 4, 1974, pp. 223-225.
    - Rubin, I.M., Plovnick, M.S. and Fry, R.E., "Who Does What Around Here? - Role Negotiations", in *Improving the Coordination of Care: A Program for Health Team Development*, Cambridge, MA, Ballinger Publishing Company, 1975, pp. 95-139.
    - Schein, E.H., "Functional Roles of Group Members", in *Process Consultation: Its Role in Organization Development*, Reading, MA, Addision-Wesley Publishing Company, 1969, pp. 38-45.
    - Sherwood, J. and Glidewell, J., "Planned Renegotiation: A Norm-Setting OD Intervention", in Bennis et al (eds.), *Interpersonal Dynamics*, third edition, New York, Dorsey Press, 1973.

A Model of the Session

Opening Remarks

- Review the previous session and respond to any questions.

- Review the purpose, agenda, and expected outcomes of this session and request group agreement.

- Respond to any questions.

Presentation

- Present short statement concerning roles and the necessity for role clarity and congruity for all team members:

    - Team ineffectiveness and interpersonal conflict are frequently created or exaggerated by role ambiguity or role conflict. Role negotiation is a specific technique for resolving role ambiguity and role conflict.
    - The first step in role negotiation is communication between team members of role expectations (that is, the expectations of the functions to be performed) that each has of the others. Role expectations are communicated through written role messages.

- Explain role messages in terms of their purpose, elements, and direction:

  - A role message requests an individual team member to do more of something, less of something or to continue to do the same amount of something.
  - A role message explains why this should be done, that is, how it will help the sender to do a better job in meeting the goals of the team.
  - The message should not be vague but should be as specific as possible.
  - The message should be

    - tied to the agreed-on goals
    - specifically directed to behavior to be changed or continued
    - not personally threatening for the receiver.

- Point out that the response to a role message that is clear and acceptable tends to be positive.

- Describe the alternative responses to a role message that requires negotiation to resolve or to reach an alternative solution. These responses may include:

  - It is ambiguous and needs clarification.
  - It is in conflict with abilities or other obligations of the receiver and needs alternative suggestions.
  - It is in conflict with role messages from other team members and needs others to do other things.
  - It is in conflict with the time available to do it and needs alternative work organization.

- Explain that role messages and the resulting contracts need to be in written form in order to demand attention, reduce misunderstandings, and increase personal commitment to fulfilling role expectations.

Exercise

- Request participants, if they have not already done so as homework, to prepare in writing an open and honest message for each of the other participants, and to be sure the name of receiver and sender is shown. Remind them that these messages will be read aloud and that a "good" role message is:

  - Tied to goals,
  - Behaviorally specific, and
  - Non-threatening (if possible), problem-oriented.

- When sufficient time has been allowed for the completion of these messages, request participants to exchange the messages so that each has only all those directed to him or her.

- Request each participant to review and categorize each message received as being one of the following:

  - Message is clear, understood and acceptable.
  - Message is unclear, not understood, needs negotiation to clarify.
  - Message is in conflict in some way and needs negotiation to resolve.

- Request two or three participants to read aloud some of the messages received, and assist them in distinguishing whether or not the message is ambiguous, vague, or specific and clear.

- Request a participant, who is comfortable in doing so, to read a message received that is unclear and/or conflicting, and to negotiate with the sender, in front of the rest of the group. Facilitate the process: the clarification of words and messages, the negotiation, and either the establishment of a written contract or the scheduling of a future date and time for the two members to complete the negotiation and secure a contract.

- Appoint someone or request a volunteer to record the dates of the scheduled meetings and the completed contracts.

- Repeat this process in the remainder of the time available.

Closing Remarks

- Assign homework for the next session. This may consist of requesting each participant to review each role message he or she received, place it in one of three categories, and formulate a response to each.

  - Do more of . . . .
  - Do less of . . . .

  - Do the same amount of . . . .

- Confirm the topic and activity planned for the next session.
- Facilitate the group's evaluation of this session, and reassure those feeling particularly uncomfortable with the process.

Session 5. Role Definition and Renegotiation

Purposes of the Session:

- To continue to develop skills in role negotiation, to negotiate participant-initiated role messages, and to schedule any needed additional negotiations, and
- To learn the procedure for periodic role renegotiation.

Preparation by the Participants for the Session:

Request participants at the previous session to review each role message received, place it in a category (do more of, do less of, do the same amount of), and formulate a response to each. Recommend that prescribed reading be reviewed.

Preparation by the Trainer for the Session:

- Review sections of the series: Monograph 2, Chapter III; Monograph 4, Chapter III.
- Utilize recommended major written resources, if desired:
    - Harrison, R., "Role Negotiation: A Tough Minded Approach to Team Development", in Bennis et al (eds.), Interpersonal Dynamics, third edition, New York, Dorsey Press, 1973.
    - Love, J.I. and Herranen, M., "Conflict in Teamwork: Understanding Roles and Relationships", Social Work in Health Care, 3:3, Spring 1978, pp. 323-330.
    - Mellette, S.J., "Interdisciplinary Teams in the Home Care of the Cancer Patient", in Kutscher, A. and Kutscher, L. (eds.), Proceedings of the Foundation of Thanatology, Home Health Care and Quality of Life, New York, Columbia Presbyterian Medical Center, April 1976.
    - Reynolds, D.K., "Work Roles in Death-Related Occupations", Journal of Vocational Behavior, 4, 1974, pp. 223-225.
    - Rubin, I.M., Plovnick, M.S., and Fry, R.E., "Who Does What Around Here? - Role Negotiations", in Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Company, 1975, pp. 94-139.
    - Schein, E.H., "Functional Roles of Group Members", in Process Consultation: Its Role in Organization Development, Reading MA, Addison-Wesley Publishing Company, 1969, pp. 38-45.

●● Sherwood, J. and Glidewell, J., "Planned Renegotiation: A Norm-Setting OD Intervention", in Bennis et al (eds.), Interpersonal Dynamics, third edition, New York, Dorsey Press, 1973.

A Model of the Session:

Opening Remarks

- Review the activities of the previous session, emphasizing that that session and this one are for skill learning which requires repeated practice.
- Review the agenda and expected outcomes of this session and request group agreement.
- Respond to any questions.

Exercise

- Request each participant in turn to read aloud and respond to each of the role messages he or she received. Response may include requesting clarification from the sender, minor negotiation, or scheduling of a data and time for major, time consuming negotiation. Should the message be acceptable (originally or following the clarification and negotiation in the group), the receiver and sender are to complete the contract, sign it, and set a date for its review (and, if necessary, for its renegotiation).
- Facilitate this process for each participant, making sure the major, time-consuming negotiations are postponed, and the pace is kept up so that all participants have time to complete their lists. (The trainer may determine that it is wise to allow a particular negotiation to continue if it is a significant issue being faced by the group and if, in his or her judgment, the timing and comfort level are right for all in the group to progress toward a resolution. If this does occur, closure and mutual support may be needed before the session ends.)
- Facilitate a general discussion by the group of the negotiation process and how it can be improved, either following each participant's presentation or after all have taken their turns.

Closing Remarks

- Review the session and the process of negotiation and renegotiation.

- Remind the group not to assume that once problems are resolved they will stay that way:

    - Things continually change - patients, environment, staff (some may leave, new members may join the team) - so roles need to change to fit the new situation. The skills learned in these two sessions will enable the team members to renegotiate on a continuing basis.
    - Role messages need to be written until all team members are comfortable with the process and may then be verbal, if desired. However, contracts always need to be written, signed, and a review date specified.

- Solicit comments, questions and evaluations of the sessions.

- Reconfirm the next session and assign homework (if any).

3. EXAMPLES FROM HOSPICE TRAINING EXPERIENCE: ROLES

The following examples provide a flavor of the training but do not necessarily have applications in all settings. Each hospice site requires specific training to meet its own needs and goals. The inclusion of these examples in this section is not intended in any way to direct or limit the development of the trainer's and the hospice team's own materials. The examples are not verbatim transcripts but are sufficiently accurate to convey the session's content.

(a) Examples of Trainer Statements Concerning Role Negotiation

These remarks were made at different points when appropriate in the sessions.

> A role message must be behavioral. You need to take the sting out, make it task-oriented. It should not be evaluative of the person. It should say something like "My job would be easier if you could . . . ". It needs to have a task focus which leads to a task-related solution, in "getting the work done that we've all agreed on". It's not related to personality or style -- it's a more rational procedure.

* * * * *

> A question has come up again after we had agreed on it in the goal statement. Role messages may relate to goal conflicts. If you think there are other approaches to this question, then these should be discussed. You always go back to a discussion of goals if they're not clear. It would be good to discuss it in another staff meeting
>
> It is important to distinguish between goal conflict and role conflict. Role conflict can be resolved if goals are agreed. Goal conflict may be:
>
> (a) resolved, with complete agreement,
>
> (b) a compromise reached, or
>
> (c) unresolved, to the point where perhaps one or some members can't stay on the team. Team members need to buy in. They can't be chronically dissatisfied or the group will become a non-team.

* * * * *

It is important then to write it out. The most important thing is not to get fuzzy in your solutions. A role message does need to be talked about, but it also must be kept track of or it will get lost. I'm watching this and see that things have a tendency to get lost - we move from subject to subject. It would be a good thing for everyone to be aware of this. The idea in role negotiation is to come up with an answer or a concrete resolution - or to agree that this can't be done. You must bring everything to closure, otherwise you'll be doing it again next week.

People tend to feel uncomfortable in coming to closure, so it's better to do it once than several times. And be sure to include dates and times.

* * * * *

I was happy to see a push toward concreteness as we went along. Always be sure of what you want and be sure you walk away with an answer.

* * * * *

A role message for everyone is that if you find this useful, keep doing it on a day-to-day basis. Some other groups have a periodic session - a maintenance session - every month or so. Never assume that once problems are solved they'll stay that way. This is a mechanism for problem solving.

(b) Example of a Role Message and Its Resolution

This example is of a simple, quickly resolved role message. Many others have been longer, requiring considerable discussion and touching on sensitive issues.

Volunteer Coordinator: I have received a role message from (a home care nurse) that reads: "I need to know the names of the volunteers assigned to my patients and when they visit the patients, so that I can better coordinate the care." That's clear to me and o.k. - but how should I do this?

Nurse (the sender): The same way it's done with the aides.

Another Nurse: Do we need to redesign the sheet we now use for the aides so that it also includes volunteers, and, perhaps, chaplains? Should it include a place for this phone number?

Volunteer Coordinator: Let's keep the phone numbers in the staff book, as we've been doing. I'll change the form to include volunteers and chaplains and enter the information there. I can have it done within the next week. Is that o.k.?

Nurse (the sender): That's fine.

Trainer: That's a good role message, well concluded. Sign it and you now have a contract.

E. REFERENCES FOR TRAINING: ROLES

Selected resource materials are supplied here for the use of trainers, participants and others concerned. They are specific to organization development, team building, and health care groups. Most do not relate directly to hospices or hospice role problems, since little is available at this time. These references are intended to provide alternative methodologies and approaches to the resolution of role issues, and to contribute to an understanding of the impact of role problems on the functioning of the team.

These materials are listed alphabetically, by author. When an item is particularly applicable to one or more of the three identified role issues, it is coded at the end of the citation as follows:

(1) Role Ambiguity/Clarity
(2) Role Conflict/Resolution
(3) Role Blurring

Bales, R.F. and Slater, P., "Role Differentiation in Small Decision-Making Groups", in Parsons, T. and Bales, R. (eds.), Family Socialization and Interaction Process, Glencoe, IL, Free Press, 1975.

Beszterczey, A., "Staff Stress in Newly-Developed Palliative Care Service: The Psychiatrist's Role", Canadian Psychiatric Association Journal, 22:7, November 1977, pp. 347-353.

Challela, M., "The Interdisciplinary Team: A Role Definition in Nursing", Image, 11:1, 1979, pp. 9-15.

Ducanis, A.J. and Golin, A.K., "The Professions", in The Interdisciplinary Health Care Team, Germantown, MD, Aspen Systems Corporation, 1979, pp. 11-30. (1)

Harrison, R., "Role Negotiation: A Tough Minded Approach to Team Development", in Bennis et al (eds.), Interpersonal Dynamics, third edition, New York, Dorsey Press, 1973. (1)(2)

Kahn, M., "Toward Collaborative Health Practice: Teaching-Learning Teams", Journal of Allied Health, 6, 1977, pp. 28-34. (1)

Love, J.I. and Herranen, M., "Conflict in Teamwork: Understanding Roles and Relationships", Social Work in Health Care, 3:3, Spring 1978, pp. 323-330. (2)

Marquis, D.B., "Individual Responsibility and Group Decisions Involving Risk", Industrial Management Review, 3, 1962, pp. 8-23.

Mase, D.J., "Professionalism and the Health Care Team", Journal of Allied Health, 4, 1975, pp. 25-32.

Mellette, S.J., "Interdisciplinary Teams in the Home Care of the Cancer Patient", in Kutscher, A. and Kutscher, L. (eds.), Proceedings of the Foundation of Thanatology, Home Health Care and Quality of Life, New York, Columbia Presbyterian Medical Center, 1976. (3)

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Rubin, I.M., Plovnick, M.S. and Fry, R.E., "Who Does What Around Here? - Role Definition", in Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Company, 1975, pp. 121-140. (1)

Rubin, I.M., Plovnick, M.S. and Fry, R.E., "Who Does What Around Here? - Role Negotiations", In Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Company, 1975, pp. 95-120. (2)

Sherwood, J. and Glidewell, J., "Planned Renegotiation: A Norm-Setting OD Intervention", in Bennis et al (eds.), Interpersonal Dynamics, third edition, New York, Dorsey Press, 1973.

Stueks, A.M., "Working Together Collaboratively With Other Professions", Community Mental Health Journal, 1:4, 1965, pp. 316-319. (1)(3)

Wallach, M.A. and Kogan, N., "The Roles of Information, Discussion and Consensus in Group Risk-Taking", Journal of Experimental Social Psychology, 1, 1965, pp. 1-19.

CHAPTER IV

TRAINING CATEGORY 3: STRUCTURE

A. Introduction

Goals, roles, and structure are all distinct yet interrelated topics of team development. The term "structure" used in this monograph includes three aspects: first, the formal organization structure of the hospice and, if it is part of another organization, the place of the hospice in that organization; second, the personnel policies that govern the staffing and the staff's working conditions in the hospice; and, third, the team structure: the size, membership and organization of the team or teams within the hospice. It does not refer to leadership, norms, or interrelationship and communication between teams or organizations, all of which are covered under the topic Procedures, in Chapter V.

Some trainers prefer to consider structure after the fourth category, Procedures. However, since much of ELM's hospice training experience structure preceeded procedures, this order is followed in this monograph. The trainer should develop the order of sessions based on the needs of each individual hospice.

The topic of structure is interrelated with that of goals and of roles, since, on the one hand, goals and roles can be determined only within an existing structure, and, on the other, only when goals and roles are investigated can structural impact and adequacy be clearly identified. For example, in some hospice situations, problems in formal organization structure have been seen to be so crucial as to need resolution before successful team building could begin, while in others, existing problems were addressed appropriately as part of the team training process, following the sessions on goals and roles. The former tend to be formal organization problems, the latter, team structure problems.

1. Formal Organization

As described in Monograph 2, Chapter II, C., hospices may be either:

- Independent (or freestanding) incorporated organizations, which provide care or coordinate care provided by others, or
- Dependent (or institution-based) programs, which are part of one or more larger organizations, such as hospitals, nursing homes, or home health agencies. Most of these programs provide care, contracting for only those services they cannot provide themselves.

The formal organization of the hospice, or of the larger organization of which it is a part, may be categorized as one of these structures: a functional organization, a product (or program or project team) organization, or a matrix organization*. The trainer with an organization development background needs no clarification in this area, except to indicate that hospices tend to be product or matrix organizations.

The position of the hospice in a larger organization is crucial to its growth, success and even its continued existence. Its position is evidence of the larger organization's commitment to the hospice concept. If a hospice is part of a hospital, it draws patients from a number of hospital departments (including medicine, surgery, oncology and gynecology), and draws resources from other departments (such as social service, physical therapy, chaplaincy, and dietary). It therefore needs to be at least at the same level in the organizational structure as other major departments. A hospice established at a lower level, such as part of another department, tends to experience major difficulties in both viability and program autonomy, which in turn have a significant impact on team function.**

Here, the formal organization of a hospice includes the job descriptions (or position descriptions) for all personnel, including supervisory, administrative and patient care staff and volunteers. Job descriptions interrelate with both position accountability in the organization and roles in the team, as discussed previously in Chapter II.

2. Personnel Policies

The personnel policies of the hospice, concerned with hours of work, leaves of absence, salary rates, fringe benefits, and the recruitment and selection of paid staff and volunteers, are part of the structure within which the hospice staff works, and affect the staff's ability to perform roles and to cope with the stress of hospice activity. For the hospice within a larger organization, its autonomy affects its ability to accomplish the functions of employing staff, determining staff-patient ratios, and allowing time off or reduced hours of work for stress management. For the independent hospice, its autonomy is clear but it may not have the financial resources to accomplish these functions appropriately.

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* Gulick, Luther, and Urwick, Lyndall F., editors, Papers on the Science of Administration, New York, Institute of Public Administration, Columbia University, 1937.

3. Team Structure

The structure of the hospice team or teams is a major part of the topic of structure. It has been discussed previously in Monograph 1, Chapter IV and Monograph 2, Chapter III, in relation to determining the team to be trained. In this monograph, if the topic of structure is covered in the training in sequence following the topics goals and roles, the team to be trained can be assumed to be already determined. However, an important part of the training may be the identification of the "ideal" team membership or the reorganization of the entire team structure.

Questions to be addressed may include:

- How many teams should there be?
- Who should be on the (each) team?
- How big can a team be?
- How does size affect function?
- How many disciplines need to be included for a team to be considered interdisciplinary?
- Should the patient and/or family be part of the patient care team(s), and, if so, how is this accomplished?

Here, again, the interdependence of these training topics may be seen: roles may determine team membership, and team membership may determine roles.

This chapter addresses these three aspects of structure under the following headings:

- Hospice Specific Examples: Structure
- Issues in Training: Structure
- Approaches to Training: Structure
  - Background Information for Trainers
  - Outline of Training

    Session 6. Structure
  - Examples from Hospice Training Experience
- Selected References for Training: Structure.

B. HOSPICE SPECIFIC EXAMPLES: STRUCTURE

Examples of structure in independent and dependent hospices identified through hospice experience are described below in Exhibits 15 and 16. They are intended to show the trainer the variety of structural situations in hospices. No value judgments are placed on these examples.

EXHIBIT 15

Examples of Structures in Independent Hospices

- One hospice's formal organization chart shows all staff and volunteers reporting to the executive director.
- Another hospice's formal organization chart shows all staff and volunteers reporting to both the executive director and the medical director.
- In one newly developed hospice, no job titles or job descriptions have been formalized for staff positions.
- There is a board of trustees but no executive director or other formal administrative management position in another hospice.
- Employment policies have not been established in one hospice; terms of employment are negotiated individually between the executive director and prospective staff members.
- The membership of one hospice team includes the entire staff for home care, inpatient care and administration.
- A hospice staff is divided into six teams: a management team, a home care team, a bereavement team, and three inpatient teams - one for each shift. Some staff members, such as the medical director, are members of all teams.

EXHIBIT 16

Examples of Structures in Dependent Hospices

- One hospice is part of the oncology service which is part of the department of medicine of the hospital.
- Another hospice reports directly to the executive director of the hospital.
- There are formal job descriptions for the hospice inpatient unit staff of a hospital but not for the home care staff of the contracted home health agency.
- In one hospice,the administrator reports to the medical director.
- Only paid staff of a hospice are considered team members.
- The personnel policies of one hospital apply without exception to the staff of the hospice.

C. Issues In Training: Structure

The lack of attention to structure, or the inability to transfer structural information to staff, affects the performance of the interdisciplinary team in providing humanistic patient care. Some structural issues, however, may not be affected by team training or team decisions. The issues discussed in this section are:

- Formal Organization/Authority Issues
- Personnel Policies/Staff Development Issues
- Team Composition/Structure Issues

Management teams in independent hospices can have a major impact on these issues, while those in dependent hospices may have little or none, depending on the position of the hospice in relation to the larger organization. Patient care teams usually have no power to affect either of these issues formally; team training may, however, enable them to accommodate to these situations as part of the environment in which they work. Team composition/structure issues are properly team training issues in any setting and for any team, although the power of the team to change its structure may be limited by outside authorities.

The relationships of structure issues to dependent and independent hospices for the categories listed above are displayed graphically in Exhibit 17, following.

Exhibit 17
Relationships of Structure Issues to Hospice Models

PROCESS ISSUES	HOSPICE MODELS	
	Independent	Dependent
Formal Organization/Authority Issues		
Personnel Policies/Staff Development Issues		
Team Composition/Structure Issues		

Illustrations of the three structure issues as they apply to hospice situations are presented on the following pages to enhance the trainer's understanding of the hospice milieu.

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1. Illustrations of Formal Organization/Authority Issues

PROCESS ISSUES	HOSPICE MODELS	
	Independent	Dependent
Formal Organization/ Authority Issues	(a)	(b)

(a) Formal Organization Issues - Independent Hospices

- In a newly incorporated home care hospice, no formal organization chart had been developed and no job descriptions written. Considerable anxiety was expressed by staff members and volunteers who did not know their job titles nor to whom they reported.
- Because of insufficient funding, a hospice home care program decided to get along without an executive director, and to have all supervisors reporting directly to the Board of Trustees, which met monthly. The ineffectiveness of the community board in making day-to-day management decisions and the lack of anyone responsible for financial and business management were major factors in leading the hospice to the brink of dissolution.
- Major difficulties arose in one independent hospice where all staff reported to both the executive director and the medical director because these two directors frequently clashed and could not reach agreement on performance priorities.
- Without written job descriptions, hospice staff members were unclear as to their formal responsibilities, resulting in duplication of effort and, in some cases, important things falling through the cracks.

(b) Formal Organization Issues - Dependent Hospices

- In a hospice inpatient unit in a hospital there was confusion in the minds of a number of nurses as to whether they reported to the nominal head nurse or directly to the program director.
- In a hospital based hospice program, staff members reported formally to the hospital directors of each discipline (nursing, social service, etc.) but were expected to perform their day-to-day work as an interdisciplinary team under the direction of the hospice director. They sometimes found themselves in the middle

of a conflict between two sets of directives.

- A hospice director, reporting to the director of the oncology program in a hospital, suddenly found a new oncology director was employed. Hospice was not a priority for the new director and the hospice director lost so much status and power that the hospice program itself was no longer viable.
- An enthusiastic hospice nurse in a hospital inpatient unit agreed to be interviewed for television on the unit, apparently unaware that hospice approval was also required. The lack of clear lines of authority and regulations resulted in the nurse losing her job.

2. Illustrations of Personnel Policies/Staff Development Issues

PROCESS ISSUES	HOSPICE MODELS	
	Independent	Dependent
Personnel Policies/ Staff Development Issues	(a)	(b)

(a) Personnel Policies Issues - Independent Hospices

- A newly established independent hospice began recruiting a home care coordinator and suddenly recognized it had not developed a fringe benefit package appropriate to its financial situation. The person hired for the position named and received his own package which was more than the hospice could afford.
- In an independent hospice home health agency, staff were paid by the hour, for reimbursement and accounting purposes. The staff members, however, felt insecure and angry that they did not receive a regular salary they could count on.
- Because of the stressful nature of hospice work, staff in one home care program felt "full time" should mean thirty-two rather than forty hours, but were unable to obtain management approval.
- Salary rates for nurses in one hospice home care program were lower than normally paid for similar work in local hospitals. However, the nurses found the work so worthwhile and personally meaningful that none resigned. The chief disadvantage of this policy was that nurse recruit-

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ment continued to be a problem for the hospice.

- In another home care program, volunteers were not permitted to drive patients in their cars either for doctors' appointments or for pleasure because the hospice policy was not to purchase the insurance that would be needed for this. The volunteers felt embarrassed as they waited with patients for taxis while their own cars were parked in front of the patient's homes.

(b) Personnel Policies Issues - Dependent Hospices

- Because of a union agreement in one hospital, new or replacement positions needed to be offered first to hospital employees. The hospice program in the hospital at times found itself unable to hire the best person for the job from outside because another hospital employee filled the written requirements.

- In an inpatient unit, the four day week was a policy of the hospice, through the introduction of the ten-hour day. However, patient care staff, who also wanted a four day week, resisted the change because of the inconvenience to their personal lives of the ten-hour day. It was not clear who had authority to make or break the decision.

- In one hospice the employment of volunteers without sufficient selection and training resulted in some volunteers, who were religious evangelists, attempting death bed conversions, completely counter to the concept of hospice. The resulting firing of volunteers led to unrest among the others, as well as loss of some community support.

- At the death of one patient in a hospice inpatient unit, a nurse who had cared for the patient and had felt very close to her requested time off to grieve. However, the policy of the hospital was not to allow this kind of leave of absence and the request was refused. The hospice soon lost the nurse and her skills in hospice care.

- In another inpatient hospice, the local nursing shortage was so great, and the training staff so busy with other tasks, that the hospice decided not to conduct periodic staff reviews in case they might lead to increased staff turnovers. The staff, without direction, provided less than ideal patient care.

3. ILLUSTRATIONS OF TEAM COMPOSITION/STRUCTURE ISSUES

PROCESS ISSUES	HOSPICE MODELS	
	Independent	Dependent
Team Composition/ Structure Issues	(a)	(b)

(a) Team Structure Issues - Independent Hospices

- In an independent hospice, team membership was an issue. Many staff members worked elsewhere most of the time, contributing only a few hours a week to the hospice, while a few - primarily nurses and nurse aides - worked for the hospice full time. The full time staff felt they alone formed the team, but recognized, in so doing, that the team was not then interdisciplinary, with a loss of quality of care to its patients and families.

- In a home care hospice, any nurse could be caring for any patient and could be coordinating the care with any of the volunteers, aides, chaplains or therapists. Everyone considered themselves part of the team. The load on the nurses in coordinating this large a group took a great deal of time away from the nurses' care of their patients.

- In another hospice home care team, the size of the team was so cumbersome and the number of patients cared for was so large that the staff could find neither the time nor the method to include the patient and family in the team. This reduced both the quality of patient care and the growth of staff understanding and skills.

- One hospice team, believing a team meant a true democracy, made all decisions by majority vote. However, decision making took so long and formal responsibility for the patients' care was so jointly shared that patient care suffered.

- A home care hospice team established three levels of membership: care team members, supporting members (resource personnel), and consulting members (temporary members). For the team, communication between members regarding both patient care information and team function skills was a major problem.

(b) Team Structure Issues - Dependent Hospices

- In one hospital based hospice, there was a management team, an inpatient care team, a home care team and a bereavement team. Although some members overlapped, each team was able to address the problems of its particular component effectively. The only major problem was that of coordination between teams.

- In a large hospice inpatient unit, the staff could never all meet together as a team, both because of shift work and because the patients could not be left unattended. Serious attention had to be paid to communication procedures to keep the team functioning well with this structure.

- In another inpatient unit, three teams were set up, one for each shift. However here, the organization structure of the hospital mandated the frequent transferring of staff from shift to shift, resulting in inter-team communication problems between shifts.

D. APPROACHES TO TRAINING: STRUCTURE

Clearly, not all structure issues can be resolved through regular interdisciplinary team training sessions. Those issues that relate to larger institutional structures or external financial regulatory organizations can best be addressed by the team in terms of the environment to which the team needs to adapt, and are covered in the chapter on Procedures (Chapter V). Training in team skills and team decision making can consider most effectively team composition and structure, and this topic is the major focus of this section. This section provides: background information for the trainer, training session outlines for a proposal training session, and examples from hospice training experience. This section is intended to assist trainers in directing their skills to the hospice situation.

1. BACKGROUND INFORMATION FOR TRAINERS

(a) Timing of Sessions on Structure

The needs of the team being trained will determine whether or not structure is a needed training topic, and, if so, where it fits best in the training schedule. If the team is very large, and/or if its members have diverse and time-consuming coordination problems, it may be wise to discuss changing the structure early in the training program. If there are serious obstacles to change in the minds of the participant, it may be necessary to address structure periodically throughout the sessions in the hope of reaching a consensus on the best organization for the well functioning team or teams by the time the formal training sessions end. A conflict may also arise as to who decides the team structure, the director or the team members; if the director is prepared for the team to decide, he or she should make this explicitly clear to the team. Special staff meetings may need to be held apart from the training sessions to address particular aspects of team structure and membership, with reports of these meetings fed back to the team training sessions.

The issues of formal organization and personnel policies, if they are of strong team concern, may need to be addressed prior to the training or only in sessions with the management team, in terms of resolution of the issues. The patient care team or teams may not be in a position to affect these issues.

(b) Trainer Planning of Training Session on Structure

One session on structure is anticipated for patient care teams. Rough estimates of the time for each portion of the session are (based on a three-hour session): ten minutes for opening remarks, fifteen minutes for the presentation, twenty minutes for closing remarks (including evaluation), and the balance of the time for the activity/exercise.

Prior to this training session dealing with the structure and leadership of the team, it is important for the trainer to review this topic with the hospice director, in order to:

- Ensure that the director agrees to the discussion,
- Determine the decision maker in the area of structure, and
- Assure the director that he or she is in charge, and that no "surprises" will occur during the session on the part of the trainer.

If a management team is being trained, and if it can have an impact on formal organization and/or personal policies (and this may well be true of management teams in independent hospices), then the issues of formal organization and personnel policies may need to be addressed in a management team training session. Although no session outline is included in this chapter for such a session, it is anticipated that it would follow a format similar to the team structure session that is presented.

(c) Trainer Behavior in Training Session on Structure

The behavior of the trainer for this session is not the same as for those on goals and roles. Here the trainer plays a more participatory role. Although the trainer acts as facilitator, he or she also contributes suggestions, as well as knowledge from other sources. This is a problem solving session. The trainer needs to:

- Keep the participants on track to reach a solution,
- Suggest alternatives to solve difficulties raised by participants,
- Recommend meetings apart from the training sessions to address complicated situations,
- Ensure, if the director has agreed the decision is to be a group decision, that supervisory members do not dominate or play a more directive role than any other members, and
- Encourage the group to set dates for procedural decision making and for implementation, if a new structure is to be developed.

2. OUTLINE OF TRAINING: STRUCTURE

One proposed structure session (Training Session No. 6) is outlined here, although more than one session may be required in some hospices. This session is to follow a meeting between the trainer and the director on the subject of structure. The outline is presented under the following headings:

- Purposes of the Session.
- Preparation by the Participants for the Session.
- Preparation by the Trainer for the Session.
- A Model of the Session:
  - Opening Remarks
  - Presentation
  - Activity/Exercise
  - Closing Remarks and Session Evaluation.

Session 6. Structure

Purposes of the Session:

- To address the structure of the team and its implications for its members, and to look at the meetings necessary to support the team structure,
- To modify, or recommend modifications to, this structure, if modification is thought to improve team function and patient/family care, and
- To improve the existing team function, if no major structural modification is recommended, in terms of membership, size, leadership, and interrelationships with other teams or organizations.

Preparation by the Participants for the Session:

There is no specific preparation recommended.

Preparation by the Trainer for the Session:

- Review the sections of the series: Monograph 2, Chapter II; Monograph 3, Chapter II, V, VI, VII; Monograph 4, Chapter IV.
- Utilize recommended written resources, if desired:

    - Beckhard, R., "Organizational Implications of Team Building: The Larger Picture", in Wise, H., Beckhard, R., Rubin, I., and Kyte, A.L. (eds.), Making Health Teams Work, Cambridge, MA, Ballinger Publishing Company, 1974.
    - Goodstein, L.D., Lubin, B. and Lubin, A.W. (eds.), Organizational Change Source Book II: University Associates, 1979.
    - Weisbord, M.R., Leader's Guide: Diagnosing Your Organization, Wynnewood, PA. Organization Research and Development, 1976.

A Model of the Session

Opening Remarks

- Review the previous session and respond to any questions.
- Review the purpose, agenda and expected outcomes of this session and request group agreement.
- Respond to any questions.

Presentation

- Present, on the flipchart or blackboard, an organization/coordination chart of the existing structure of the team, and review its implications with the team:
    - The number of people that each nurse (or other person in charge of the patient's care) coordinates, in comparison to the "ideal" or to other studies. (One study concluded that a span of control in excess of seven is effective.)
    - The time spent in various activities of the staff, including the time spent coordinating, record-keeping, and travelling (home care).
    - The effectiveness of the structure in meeting the goals of the team and in meeting the needs of the team members.
    - The meetings needed to maintain the existing structure and their effectiveness.

Activity/Exercise

- Solicit participant reactions and facilitate discussion of the existing structure.

- Record suggestions, alternative structures or modifications on the flip chart/blackboard as they are suggested by the individual participants, as well as the stated advantages and disadvantages of both the existing and proposed systems.

- If agreed to by the director, present on the flip chart/ blackboard an alternative team structure, and facilitate discussion of it.

- List the advantages and disadvantages of this proposed structure, based on opinions expressed by participants and on own insights.

- Facilitate discussion of potential changes needed in procedures, roles, etc., to make the proposed structure effective.

- Facilitate discussion of the meetings needed, and the total time for meetings for the proposed structure compared to the present system.

- Facilitate any modifications to the proposed structure (if consensus is reached that this should be the structure) to meet constraints of the hospice, the team members and, if applicable, the proposed additional team members.

- If a new structure is agreed on, assist the participants in determining the implementation steps and in establishing an implementation time line.

- Appoint someone, or request a volunteer, to record the decisions and implementation steps agreed to by the group.

- If no new structure is agreed on, review with the participants the advantages and disadvantages of the existing structure and methods of addressing the disadvantages.

Closing Remarks

- Facilitate the group's evaluation of the session. (If consensus is not reached, arrange for further discussion at another training session, if appropriate.) Forewarn the group, if it is planning a change, that there is always resistance to change, and advise the group to utilize learned skills. If appropriate, congratulate the group on its demonstrated ability to make group decisions.

- Confirm the topic and activity planned for the next session. Assign homework, if any.

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3. EXAMPLES FROM HOSPICE TRAINING SESSIONS: STRUCTURE

There are few examples from hospice training experience that would be useful to trainers, since the team composition and organization issues tend to be specific to each hospice, and since the sessions are problem-solving rather than skill learning.

In one home care hospice, a core team decided to change to a format of several home care teams, each led by a home care nurse. Disciplines including nurse aides, chaplains, and volunteers, which were not included in the original core team, would participate as members of the new teams. In the team training session of the core team when the change was concluded, some statements made by the trainer may be of value. These statements are not verbatim transcripts but are sufficiently accurate to convey the meaning intended.

> In your present structure, each nurse is coordinating the efforts of maybe sixty people . . . It's hard to establish predictable interactions between people as there are so many. It takes a lot of time to coordinate all these people, particularly as there is always a new team for each patient . . . The question is, should this much time be spent in managing an inefficient operation, or should the time be spent reorganizing it? Previously you have mentioned ideas of different structural configurations.

* * * * *

> There is a trade off between coordination and flexibility. When drawing on a large pool of people, the more flexible, but the less predictable and coordinated, is the program.

* * * * *

> If you have several home care teams, each led by a nurse, the major advantage is that people have a working relationship with ten or eleven people, as opposed to the sixty or so now. That closeness encourages development of your own ways of doing things, plus better continuity of care, etc.

* * * * *

> We need to look at the kinds and numbers of meetings that would be necessary and compare total meeting time for each discipline in the present and proposed structures.

* * * * *

There appear to be three needs: coordination, flexibility, and a management system . . . Let's look at the advantages and disadvantages of the individual home teams.

Lists on the flipchart two columns: Pros and Cons. From comments made by participants, writes:

Under Pros:

1. Input from more team members.
2. More structure, not more time.
3. More efficient use of time.
4. Cohesiveness: stronger relationships and understanding.

Under Cons:

1. Difficult to coordinate geographic distribution of patients and staff.
2. Less flexible assignments.

* * * * *

To define the membership of the teams, you need to determine how to allocate staff to the team, such as, not all males on one team, a variety of volunteer skills on each team, and geographical appropriateness of staff members for each.

* * * * *

With this consensus, we need to put a time frame on the change and we need to define areas where decisions are to be made ... So, to summarize your ideas, the areas for discussion are: (1) define the team, (2) allocate areas, (3) determine procedures, meeting times and methods of allocating patients to teams, and (4) clarify the roles of those covering more than one team, such as the medical director and the social worker.

* * * * *

It should be fun to try to let it evolve over time. You'll have a chance to build a team in each of the smaller groups, to transfer skills and to improve productivity. You can expect some resistance but you're developing the skills to deal with that.

* * * * *

E. SELECTED REFERENCES FOR TRAINING: STRUCTURE

Selected resource materials are supplied here for the use of trainers, participants, and others concerned. These references assist in examining the organizational constructs which aid or preclude the productive processes needed for a well functioning team. They are intended to contribute to an understanding of the impact of structure on function.

These materials are listed alphabetically by author. When a citation is particularly applicable to one or more of the three identified structure issues, it is coded as follows:

(1) = Formal Organization/Authority
(2) = Personnel Policies/Staff Development
(3) = Team Composition/Structure.

Beckhard, R., "Organizational Implications of Team Building: The Larger Picture'. in Wise, M., Beckhard, R., Rubin, I. and Kyte, A.L. (eds.), Making Health Teams Work, Cambridge, MA, Ballinger Publishing Company, 1974. (1)

Carlins, E.B. and Raven, B.H., "Group Structure: "Attraction, Coalitions, Communication and Power", in Handbood of Social Psychology, Vol. 4, Reading, MA, Addison-Wesley, 1969, pp. 102-204. (2)(3)

Ducanis, A.J. and Golin, A.K., "Organizational Settings", in The Interdisciplinary Health Care Team, Germantown, MD, Aspen Systems Corporation, 1979, pp. 75-88.

Lammert, M.H., "Power, Authority and Status in Health Systems: A Marxian-Based Conflict Analysis", The Journal of Applied Behavioral Science, 14:3, 1978, pp. 321-333. (1)

Robbins, S., Managing Organizational Conflict, Englewood Cliffs, NJ, Prentice-Hall, 1974.

Rubin, I.M. and Beckhard, R., "Factors Influencing the Effectiveness of Health Teams", Milbank Memorial Quarterly, 1:3, 1972, pp. 317-335. (1)(2)

Tannenbaum, R. and David, S., "Values, Man and Organization", in Organization Development: Theory, Practice, and Research, Dallas, Business Publications, 1978, pp. 496-507.

Tichy, N., Organizational Design for Primary Health Care, New York, Praeger Publishers, 1977. (1)(3)

Weisbard, M.R., Diagnosing Your Organization, Wynnewood, PA, Organization Research and Development, 1976, (1)(2)

Wilson, Dottie C. and English, David J., "Issues in Hospice Administration", accepted for publication in Davidson, G.W. (Editor), The Hospice: Development and Administration, Second Edition, Washington, D.C., Hemisphere Publishing Corporation. (1) (2).

CHAPTER V

TRAINING CATEGORY 4: PROCEDURES

A. INTRODUCTION

"Procedures" is a somewhat catch-all term which includes the methods, processes, rules, norms, environment, rewards and punishments either common to the whole hospice organization and, therefore, to the team or teams within it, or specific to the team itself. The interdisciplinary team(s) can learn, through interdisciplinary team training, either to modify existing procedures, or to develop new procedures or accommodations, which will improve both team function and patient/family care provision.

Procedures which the team usually can modify and improve include decision making, problem solving, and meeting management. Other procedures, as well as some structures (as described in Chapter IV) may not be possible for the team to modify, such as those imposed either by a larger organization, of which the hospice is a part, or by a national reimbursement system to which the hospice must adapt. The team may need to accommodate to these environmental constraints by developing new procedures or coping mechanisms.

In general, this latter group may be termed "external" and the former group "internal" procedures. Both groups are considered in this chapter; the team training outlines, however deal primarily with internal, modifiable procedures.

This chapter addresses procedures under the following headings:

- Hospice Specific Examples: Procedures
- Issues in Training: Procedures
- Approaches to Training: Procedures
    - Background Information for Trainers
    - Outline of Training

      Session 7. Decision Making and Problem Solving

      Session 8. Meeting Management and Group Dynamics

      Session 9. Norms and Monitoring
    - Examples from Hospice Training Experience
- Selected References for Training: Procedures.

B. HOSPICE SPECIFIC EXAMPLES: PROCEDURES

Hospice procedures may differ from those of other organizations or teams because of the uniqueness of some hospice goals. Special procedures may be needed for hospices to meet goals such as:

- To provide humanistic care to patients and families,
- To provide continuity of care among components of care,
- To continue care of families following the death,
- To emphasize symptom management and quality of life rather than prolongation of life regardless of quality, and
- To incorporate the patient and family into the team.

Since new ground is being broken through efforts to attain some of these hospice goals, some of the procedures are new and are being developed through trial and error. However, other procedures, successfully used in other organizations, can be transposed to hospice teams to their benefit.

Some examples of hospice procedures have been accumulated here to assist in the orientation of the trainer. No value judgments are placed on these examples. They are shown below in Exhibits 18-24, under the following headings:

- Decision Making and Problem Solving
- Meeting Management and Group Dynamics
- Norms
- Leadership and Interpersonal Relationships
- Adjusting to Changes in Team Membership
- Interacting with those Outside the Team
- Team Monitoring and Evaluation.

EXHIBIT 18

Examples of Decision Making and Problem Solving Procedures

- A hospice home care nurse decides to have a patient admitted to hospital without discussing the situation with the family, and accompanies the patient to the emergency room.
- A hospice home care nurse wishes to admit a patient to hospital but first obtains the agreement of the patient, the family, the physician, and the hospital admitting office.
- The hospice director decides, to the surprise of the staff, that patients unable to pay will no longer be admitted to the hospice.
- The hospice director, after discussing with the staff a solution to the problem of low inpatient occupancy through admitting patients undergoing aggressive therapy, decides against this solution.
- All new management decisions are posted on the bulletin board. It is the responsibility of the staff to scan the bulletin board frequently for this information.

EXHIBIT 19

Examples of Procedures in Meeting Management and Group Dynamics

- Prior to all formal meetings of the team, an agenda is prepared and distributed to the participants.
- The chairpersonship of team meetings rotates weekly among the team membership.
- The objectives of the monthly management team meeting are stated and agreed at the beginning and reviewed at the end of each meeting.
- At the weekly patient care review team meetings, team members describe the condition of each patient, and the medical director decides what action, if any, is to be taken.
- Only the nursing staff attends the staff support meetings.
- Volunteers are invited to the patient care meetings but are not expected to contribute to the case reviews or decisions.

EXHIBIT 20

Examples of Norms Procedures

- The hospice director maintains an "open door" policy. It is expected that team members may drop in and chat at any time they need to.
- One must never disagree with the medical director.
- The wishes of the patient come first.
- It doesn't matter what hours a home care nurse works as long as they total forty hours and as long as the work gets done.
- Meeting the spiritual needs of patients is solely the responsibility of the chaplain.
- Team members support each other and openly express appreciation of each other.

EXHIBIT 21

Examples of Leadership and Interpersonal Relationships Procedures

- Interpersonal conflicts are reported to the supervisor(s) of those involved for resolution.
- All management team members considered themselves the leaders of the hospice.
- Leadership in hospice team meetings included both the chairperson of the meeting and the social worker who kept the discussion on track.
- The medical director, as team leader, assumed all decisions would be made by him.
- The medical director, as team leader, considered leadership to mean coordinating the knowledge and skills of the entire team membership and ensuring that a decision is made.
- All team members perform some leadership functions and some participant functions. Each tries to ensure that problems to be resolved are understood, clarified and alternative solutions considered before consensus is reached.

EXHIBIT 22

Examples of Procedures in Adjusting to Changes in Team Membership

- Whenever a team member resigned, the team bought a gift and held a farewell party.
- Sometimes a team member left without all team members knowing about it.
- A new employee was immediately allocated to follow another team member around for a few days and was then considered trained.
- Selection and orientation of new staff members was the total responsibility of the head nurse. The rest of the team usually did not meet the new member until formal orientation was complete.
- A newly employed hospice social worker couldn't seem to do anything right in the eyes of the rest of the staff as they were still grieving over the loss of the previous social worker.
- The first assignment to each new employee is to read the procedure manuals and policy manuals of the hospice.
- Before a new employee was recruited, team members were asked by the director what attitudes as well as what skills and knowledge they felt were needed.

EXHIBIT 23

Examples of Procedures for Interacting with Those Outside the Team

- The hospice team members feel that, because they are caring for the dying, all they need to do is ask for anything and it should be supplied.
- A hospice team approaches non-hospice physicians as if they were accustomed to team interaction and coordination.
- A hospice social worker visits the oncology outpatient clinic regularly for informal interaction and information sharing with the oncology social worker.
- The hospice home health agency executive director does not attempt to convince the third party payers that hospice is different from any other home care.
- A hospice medical director, lecturing to medical students, teaches the medical aspects of terminal care, not the hospice philosophy.
- A hospice director does not permit a media article to be written unless it can be reviewed by the hospice prior to publication.

EXHIBIT 24

Examples of Procedures for Team Monitoring and Evaluation

- In one hospice the staff members said they were a team, but they behaved in the hierarchical medical tradition.
- When team members were asked if the team monitored its progress, they didn't know what that meant.
- Trying to work as a team member became an additional stressor for some hospice staff, already stressed by working with dying patients.
- Staff members, stressed by their inability to make dying perfect for every patient, sought and received solace from their team.
- At the end of each team meeting, ten minutes is allocated for a review of the group process during the meeting.
- The volunteer coordinator was allocated the job of being sure that decisions made at team meetings were actually carried out.

C. ISSUES IN TRAINING: PROCEDURES

The examples of procedures in hospice in the previous section are, in themselves, indications of the issues that can and do arise around this multifaceted topic area. To function well, teams need to develop ways of doing things, whether they be unwritten norms or formalized written procedures. These procedures may refer either to accomplishing the team's tasks and attaining its goals or to the process of team function, coordination, communication and evaluation, or both. Hospice experience has shown that reaching consensus on goals is a simple task when compared to resolving major procedural battles. Also, as the lack of clearly understood procedures to map the way for resolution of conflict and to improve capacities for decision making and problem solving makes for a distorted, ambiguous, or stressful environment in which to work, the resolution of procedural issues is essential.

The procedural issues discussed here are grouped under the same seven headings used in Section B:

- Decision Making and Problem Solving
- Meeting Management and Group Dynamics
- Norms
- Leadership and Interpersonal Relationships
- Adjusting to Changes in Team Membership
- Interacting with Those Outside the Team
- Team Monitoring and Evaluation.

These issues and their resolution frequently vary depending on both the hospice component team involved (including management, home care, inpatient and bereavement teams) and whether the procedure concerns patient/family care or internal organization. The interrelationships between procedural issues and these variables are illustrated graphically in Exhibit 25, following.

EXHIBIT 25

RELATIONSHIP OF PROCEDURAL ISSUES TO EXTERNAL AND INTERNAL PROCEDURES

PROCESS ISSUES	PROCEDURES		
	Patient/Family Procedures	Internal Procedures	
		Patient Care Team(s)	Organization (Management Team)
Decision Making/ Problem Solving			
Meeting Management/Group Dynamics			
Norms			
Leadership/Interpersonal Relationships			
Team Membership Changes			
Interaction with Outsiders			
Team Monitoring/ Evaluation			

Illustrations of each of these issues as they apply to hospice situations are described below.

1. ILLUSTRATIONS OF DECISION MAKING/PROBLEM SOLVING ISSUES

PROCESS ISSUES	PROCEDURES		
	Patient/Family Procedures	Internal Procedures	
		Patient Care Team(s)	Organization (Management Team)
DECISION MAKING/ PROBLEM SOLVING	✓	✓	✓

- Decisions made by the Board of Directors of an independent hospice are based on information supplied by the executive director and are carried out by the executive director. The patient care team members feel frustrated because their opinions are not asked before the decisions are made nor are they routinely advised of the decisions and the reasons for them immediately after the board meetings. They say everyone is open to everyone else in the hospice except for the Board of Directors and they feel the executive director has something to do with this so-called "secrecy".

- The medical director solves patient care problems without prior discussions with the rest of the team, leading to anger on the part of some team members and, frequently, inappropriate solutions.

- All the team members feel they should participate in making all decisions while the hospice director believes he makes all decisions after obtaining the opinions of the rest of the team, with the result that there is anger and confusion expressed by all.

- When the management team makes a decision, no one is responsible for communicating the decision to the rest of the staff, so that the decision is seldom carried out or followed by the staff.

- In one hospice, not all problems were brought to the entire team for solution. Those involved in the decision came togehter for short periods frequently to coordinate their plans and concur on the next steps. This system enable caregivers to improve care on a day-to-day basis, and to bring only major problems to the team for full interdisciplinary consideration.

2. ILLUSTRATIONS OF MEETING MANAGEMENT/GROUP DYNAMIC ISSUES

PROCESS ISSUES	PROCEDURES		
	Patient/Family Procedures	Internal Procedures	
		Patient Care Team(s)	Organization (Management Teams)
MEETING MANAGEMENT/GROUP DYNAMICS	✓	✓	✓

- At team meetings held weekly to review patient care plans, team members frequently became sidetracked on an issue and did not cover all patients before the meeting time was over. This led to frustration on the part of those caring for the patients not discussed and negatively affected the quality of care of these patients.

- The time of the weekly case conference is not fixed in one hospice but depends on when the medical director is available. After waiting around for the meeting to start, many team members either leave or are angry about the lost time by the time the meeting begins.

- Team meetings to review cases are dominated by the physicians and nurses. Other team members - social worker, chaplain, and aides - seldom feel comfortable in contributing their perspectives to the patient care issue raised. As a result, some patient needs are not addressed and some decisions are inappropriate.

- Although management meetings are held periodically, no one knows the purpose of the meetings and many do not bother to attend. Those who do attend are unprepared to discuss the issues raised by the director. As a result, unwise decisions are frequently reached.

- Whenever a difference of opinion arises in a meeting, it is immediately smoothed over by the chaplain and the topic is changed to a more harmonious one. Through this method, the hard decisions are not addressed or resolved.

3. ILLUSTRATIONS OF ISSUES CONCERNING NORMS

PROCESS ISSUES	PROCEDURES		
	Patient/Family Procedures	Internal Procedures	
		Patient Care Team(s)	Organization (Management Team)
NORMS	✓	✓	✓

- One hospice organization emphasized flexibility as a norm to such an extent that no rules were established. Lack of consistency was a result in both staff interaction and patient care.

- The suggestions and ideas of each team member to improve patient/family care were welcomed and discussed by the rest of the team. With this encouragement, all team members read and through about innovative methods, and together tried out new approaches. This procedure resulted in individual staff growth, reduced staff stress and turnover, and improved quality of care.

- In one hospice, the highly motivated staff expected to like all the patients and families admitted to the program. On one occasion, the staff members involved virtually refused to care for a patient who criticized all care and who tried to create dissention among staff members. Only when the staff members took a more realistic approach and began to understand the meaning of the patient's behavior could a care plan and staffing plan be set up that was satisfactory to both patient and staff.

- While complete confidentiality of patients' private communications was an unwritten rule, problems frequently arose when such information was important for the team to know in reviewing patients' care plans. Also, some staff members found it difficult to remember what information was confidential in this way and what could be shared with the team. Clarification in this area was needed both to protect the patient and to maintain staff self-confidence.

4. ILLUSTRATIONS OF LEADERSHIP/INTERPERSONAL RELATIONSHIPS ISSUES

PROCESS ISSUES	PROCEDURES		
	Patient/Family Procedures	Internal Procedures	
		Patient Care Team(s)	Organization (Management Team)
LEADERSHIP/ INTERPERSONAL RELATIONSHIPS		✓	✓

- A hospice team felt that the only way to avoid a hierarchy within the team was to have the leadership rotate among the entire membership. However, this method led to a "King for a Day" attitude which exacerbated the problem.

- Total equality of all team members was the goal of one hospice home care team, with all decisions made by democratic vote. Problems arose, however, when the group got off the track and consumed too much time. They found that leaderlessness was not efficient, nor did it result in better decisions.

- Interpersonal problems tended to fester within one hospice organization as no one wanted to face the fact that hospice people have such problems. A clear procedure and a lesson in reality orientation was needed for the staff to see that even hospice people are human.

- In one hospice, the staff members of each discipline tended to form cliques and to assume that their skills and precepts were more significant to the success of the program than those of other disciplines. Interdisciplinary and interpersonal conflicts resulted, reducing the coordination necessary for high quality patient/family care.

- In a new hospice inpatient unit, a nurse felt that only she could provide the needed care for her patients and was reluctant to leave at the end of her shift. She also telephoned the unit when she was off duty to inquire about her patients. Only when the hospice took steps to improve interpersonal relationships so that all staff members learned to know each other better and trust each other, was the nurse confident that when she went home her patients were in good hands.

5. ILLUSTRATIONS OF ISSUES IN ADJUSTING TO CHANGES IN TEAM MEMBERSHIP

PROCESS ISSUES	PROCEDURES		
	Patient/Family Procedures	Internal Procedures	
		Patient Care Team(s)	Organization (Management Team)
TEAM MEMBERSHIP CHANGES		✓	

- When a home care nurse resigned, the rest of the team took over her case load. Several weeks later when a new nurse was hired, the rest of the team were so glad she was there to share the load that they helped her become acclimatized in every way they could. The adjustment for both the new nurse and the rest of the team was quick and successful.

- The entire team met a new staff nurse and tried to provide all the facts needed as quickly as possible so that she could immediately fill the job left open by one who resigned. However, since the new nurse felt overwhelmed by all these facts and found it difficult to remember everything she had been told, the rest of the team dubbed her as incompetent, and did not utilize the valuable resources she brought to the job.

- When a hospice expanded enough to engage a physician in addition to the medical director, the team immediately accepted her as a team member. However, she was accustomed to respect and obedience on the part of others and became completely confused with the team's sharing, discussion, and, at times, criticism of her unilateral decisions.

- In a home care program, a new social worker was quick to adapt to the new environment and functioned well from the start. However, his behavior intimidated the rest of the staff members, who chose to avoid using his services and to do the social work function themselves.

- When a hospice physical therapist, who was an informal group leader, decided to resign to attend medical school, the rest of the team members felt the loss deeply. Their coping mechanisms began with snubbing the new therapist and then developed into discussing at length everything they could think of that was wrong with the one who had left.

6. ILLUSTRATIONS OF ISSUES CONCERNING INTERACTING WITH THOSE OUTSIDE THE TEAM

PROCESS ISSUES	PROCEDURES		
	Patient/Family Procedures	Internal Procedures	
		Patient Care Team(s)	Organization (Management Team)
INTERACTION WITH OUTSIDERS		✓	✓

- One hospice inpatient team saw the benefits of problem-oriented charting for hospice patients. However, the larger organization of which it was a part had long established its charting procedures and was not prepared to agree to this change in such a new, small unit.

- A home care hospice contracted with a community agency for homemaker services. The team felt that coordination with the agency would improve if an agency staff person attended the team's weekly patient care meetings. However, the agency realized its staff was already overworked and felt this was an added burden it could not approve.

- In an inpatient hospice unit in a large hospital, the patient care team was upset and angry because of the way the staff from the hospital's morgue treated the bodies of those the team had cared for when the bodies were removed from the unit to the morgue. A meeting was held between these two groups. It appeared that the morgue staff found this rough treatment of bodies their way of coping with the idea of having to handle the dead.

- A local church group, enthusiastic about the concept of hospice, wanted the hospice to identify its patients so that members of the church group could visit them. The hospice organization felt the patients and families should be in charge of determining their own spiritual needs and refused to cooperate with the church group.

- A hospice management team, whose members had worked well together for a long time, approached a foundation director for fund raising purposes. The attempt ended in failure, however, because the foundation director not only was unfamiliar with the hospice concept but also was uncomfortable in the middle of such an open, trusting group and felt threatened by this new experience.

7. ILLUSTRATIONS OF TEAM MONITORING/EVALUATION ISSUES

PROCESS ISSUES	PROCEDURES		
	Patient/Family Procedures	Internal Procedures	
		Patient Care Team(s)	Organization (Management Team)
TEAM MONITORING/ EVALUATION		✓	

- One hospice team, frequently used as an example of how hospice care should be provided, collapsed when all the members threatened to resign en masse. Only when the hospice director brought in an outside consultant trained in team function, and sponsored a weekend workshop for all staff to look at what was going wrong and what could be done, were the staff members willing to consider staying on.

- In one hospice, the patient care staff called themselves a team but, because they never met together, found coordination and communication difficult. Although the quality of patient care was suffering and staff stress was high, no one seemed able to identify the problem.

- In the inpatient unit of a hospital, the team functioned well for a while and then began to deteriorate, with the development of interpersonal antagonisms and the formation of cliques. Only when a special monthly team evaluation meeting was established and a procedure set up to address any problem areas identified in this meeting, was long term stability of the team maintained.

- In a home care hospice, the team membership included only nurses and social workers. Quality of care suffered, as did interpersonal relationships between team members and other disciplines - particularly the medical director - until, in evaluating team function, the members saw the need to incorporate other disciplines into the team.

D. APPROACHES TO TRAINING: PROCEDURES

Interdisciplinary team training in procedures involves participants learning both skills and problem solving methods. Skills need to be developed for decision making, meeting management and monitoring, while gaining insights and new approaches to solving problems are required for norms, leadership, and relationships with both other organizations and with new team members. A broad spectrum of skills are required of the trainer.

This section provides background information for trainers, training session outlines for three proposed sessions, and examples from hospice training experience. Its purpose is to help prepare trainers for training hospice teams in procedural areas.

1. BACKGROUND INFORMATION FOR TRAINERS

(a) Timing of Sessions on Procedures

Training in procedures follows naturally after sessions on goals, roles and structure. By this time in the training program, it is anticipated that participants feel open and comfortable with the trainer and each other, and that they have learned and are using the skills developed in the previous sessions. The participants are probably enthusiastic about the training and ready to face some major team problems.

(b) Relationship of Training Sessions to Procedural Issues

Not all procedural issues are of concern to all hospice teams. Information learned through the data collection--which may be modified as the earlier sessions proceed--enables the trainer and the team to determine the most significant issues. It is anticipated that sessions in decision making, meeting management, norms, and monitoring are needed by most teams, while the others may or may not be issues in any one hospice group.

The session outlines provided cover the following issues, the last two issues being dealt with in one session.

- Decision Making and Problem Solving
- Meeting Management and Group Dynamics
- Norms
- Monitoring and Evaluation

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The issues for which no sessions are outlined here include:

- Leadership and Interpersonal Relationships
- Adjusting to Changes in Team Membership
- Interacting with Those Outside the Team

For these issues, the trainer will find assistance in the references cited in Section E. In particular, the following major resources may be useful:

- Farrell, M., Haley, M., and Magnasco, J., "Teaching Interpersonal Skills", Nursing Outlook, 25:5, May 1977, pp. 322-325.
- Hollister, W.G., and Edgarton, J.W., "Teaching Relationship-Building Skills", American Journal of Public Health, January 1974.
- Rasellas, C., Training Exercises to Improve Interpersonal Relations in Health Care Organizations, Greenvale, NY, Panel Publishers, 1977.
- Rubin, I.M., Plovnick, M.S., and Fry, R.E., Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Company, 1975, pp. 191-200, 213-236, 255-264.
- Soloman, L.N., and Bergon, B., Employee and Team Development, La Jolla, University Associates, 1979 (includes tapes/records).
- Walton, R.E., "Interpersonal Confrontation and Basic Third-Party Functions: A Case Study", in Organization Development: Theory, Practice and Research, Dallas, Business Publications, 1977, pp. 165-173.

(c) Trainer Planning of Training Sessions in Procedures

Three sessions are outlined. However, the third session, which covers two topics, may require two sessions in some hospices, if norms are a major area of concern and/or if monitoring over time without the facilitation of the trainer is threatening to the group. In some interdisciplinary team training programs there are enough unfinished "loose ends" that, with norms allocated a whole session, the loose ends plus monitoring becomes the final session.

In addition, as noted above, sessions on the topics not outlined here may be appropriate. It is recommended, however, that these be scheduled before the discussion of procedures for monitoring. Monitoring may best be held during the final session so that plans can be made during that session to proceed without the presence of the trainer. It is presumed that throughout the training program the trainer will have been referring to the concept of monitoring, and to the expectation that the group will continue monitoring, learning and growth indefinitely.

The time allocation for the activities of the sessions is estimated to be as follows (based on three-hour sessions): fifteen minutes each for opening and closing remarks (except for Session 9), and a ten minute break for each session. For Sessions 7 and 8, the presentation should be no longer than fifteen minutes each, and the remainder of the time spent in the exercises. In Session 9, the two presentations should take about ten minutes each, the norms exercise approximately an hour and a quarter, the monitoring activity approximately half an hour, and the closing remarks - being the closing remarks for the program - approximately half an hour.

(d) Trainer Behavior in Procedures Sessions

As the trainer and the group should be quite comfortable together by this point in the training program, there is little to contribute to what the trainer undoubtedly already knows about his or her role with the group. The following reminders, however, may be useful:

- Continue to ensure that the training proceeds in a non-threatening manner, and that neither supervisory members nor the group's "natural" leaders dominate the discussions.
- Encourage the group to address hard issues now that the comfort level has risen and before the group is left to continue its training on its own.
- Keep the group on task, and encourage the scheduling of meetings outside the training sessions for time consuming discussions. (This will also encourage the group to continue this method in future.)
- Be supportive and reassuring, particularly concerning the group's ability to continue without trainer assistance.
- Try to conclude the program in a positive, optimistic atmosphere. Leave open the possibility of a trainer visit to the group after a period of months to see how things are going, as assurance of this availability tends to support those fearful of continuing on their own.

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2. OUTLINE OF TRAINING: PROCEDURES

The three proposed training sessions in procedures (Training Program Session Nos. 7-9) are outlined in this section under the following headings:

- Purposes of the Session.
- Preparation by the Participants for the Session.
- Preparation by the Trainer for the Session.
- A Model of the Session:
    - Opening Remarks
    - Presentation
    - Exercises
    - Closing Remarks and Session Evaluation.

Session 7. Decision Making and Problem Solving

Purposes of the Session:

- To understand more clearly why team problem solving and decision making are frequently ineffective, and
- To learn and practice methods in decision making and problem solving.

Preparation by the Participants for the Session:

Request participants, at the previous session, to read specific information on this topic before this session, and to write down important decisions the team regularly makes or has made.

Preparation by the Trainer for this Session:

- Review sections of the series: Monograph 2, Chapter II; Monograph 3, Chapters II, V, VI, VII; Monograph 4, Chapters IV, V.
- Utilize recommended major written resources, if desired:
    - Eiseman, J.W., "A Third-Party Consultation Model for Resolving Recurring Conflicts Collaboratively", *The Journal of Applied Behavioral Science*, 13:3, 1977, pp. 303-314.
    - Schein, E.H., "Group Problem-Solving and Decision-Making", in *Process Consultation: Its Role in Organization Development*, Reading, MA, Addison-Wesley Publishing Company, 1969, pp. 52-58.
    - Rubin, I.M., Plovnick, M.S., and Fry, R.E., "How Things Get Done Around Here - Decision Making", in *Improving the Coordination of Care: A Program for Health Team Development*, Cambridge, MA, Ballinger Publishing Company, 1975, pp. 141-172.

A Model of the Session

Opening Remarks

- Review the previous session and respond to any questions.
- Review the purposes, agenda and expected outcomes of this session, and request group agreement. Determine how many participants completed the assigned homework.
- Respond to any questions.

Presentation

- Present short statement concerning the criteria for effective decision making:
    - quality of the decision - the problem is solved and the best decision is reached through the use of algorithms and formulae. Quality decision making requires a clear understanding of who does and who does not participate in the process.
    - acceptance of the decision and its implementation - people must be committed to the decision if it is to be carried out. All relevant people need to be involved to maximize acceptance.
    - efficiency of the decision - the quality and acceptance criteria determine the efficiency. Those who need to be involved in the decision making process are involved, others who want to be involved may be, but not everyone is involved in every decision. Everyone, however, may be involved in deciding who should be involved in making the decision.
- Describe techniques to determine who should be involved in the team decision making process. One approach, the charting technique, is a structured process by which those who need to be involved are determined by everyone in the group. There are four kinds of involvement role and one no-involvement category:

D = Decision maker - The person or persons who have a vote. If there is more than one decision maker, two things are required:

-a meeting to make the decision, and
-knowledge of how to resolve conflict and reach consensus.

C = Consultant - The person or persons who provide the data base. They are problem sharing people but not decision makers. They provide input and valuable information which contribute to the quality of the decision.

I = Informed - The person or persons not involved in decision making but involved in carrying out the decision or otherwise needing to be informed. These people do not usually attend the decision making meeting.

M = Manager - The person (one only) who manages the process. If there is more than one decision maker, it is particularly important to have a manager. In a meeting, one person is identified as manager to see that a problem is decided on, Consultants are consulted and Informed are informed, and to schedule when things are to be done. Typically, but not necessarily, a manager and a decision maker are joined.

O = No Involvement - The person or persons who have no part in the decision making process.

- Facilitate discussion and respond to questions about this technique.

Exercise

- Introduce the Decision Chart, a graphic method of deciding who should be involved and in what involvement role.

- Draw a chart on the flipchart (or blackboard) listing the decision makers (the session participants) down the left side, and all the individuals (by job title) who might be involved or affected, across the top. (A separate chart is prepared for each major team problem to be decided.)

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Example of Decision Chart

Problem to be Solved (Decision to be Made): ______________________________

Training Session Participants (decision makers re roles)	Those who might be involved in the identified problem														
	Training Session Participants							Others							
				Nurses											
	Ex. Dir.	Med. Dir.	Home Care Coord.	Sally	Bonnie	Social Worker	Dir. Vol.	Volunteers	Chaplain Coord.	Chaplains	Phys. Ther.	Aides	Nutritionist	Office Staff	
Mary, Ex. Dir.															
John, Med. Dir.															
Jane, Home Care Coordinator															
Sally, Nurse															
Bonnie, Nurse															
May, Social Worker															
Amy, Dir. of Volunteers															
CONSENSUS															

  - Facilitate the determination of a specific problem to be solved or decision to be made that currently faces this hospice team.
  - Ask each participant to write down what role each of those listed across the top of the chart should play in the decision making process for this problem (D, C, I, O, M), including his or her own role.
  - Ask each in turn to enter their decision on the flipchart/blackboard (or to read them aloud and one person enters them on the chart). Participants may add categories across the top if they feel others are involved in the problem. They should identify only one M.

- Facilitate discussion and raise questions to identify reasons for discrepancies:

  - Emphasize that the problem itself is not to be resolved, only the process for resolution is to be addressed.
  - Point out that too many D's reduces efficiency.
  - Encourage the group to reach consensus, and enter this in the last line of the chart.

- Repeat the exercise, using other problems facing the team, until the exercise time is exhausted.

Closing Remarks

- Facilitate evaluation of the session and respond to questions.

- Confirm the topic and activity for the next session and assign homework, if any.

Session 8. Meeting Management and Group Dynamics

Purposes of the Session

- To understand the problems in conducting and contributing to meetings, and
- To learn some techniques and strategies to improve the effectiveness of meetings.

Preparation by the Participants for the Session

At the previous session, request participants to read specific designated information on the topic before the session. (Example: Rubin, I.M., Plovnick, M.S., and Fry, R.E., "Running a Better Meeting", in *Improving the Coordination of Care: A Program for Health Team Development*, Cambridge, MA, Ballinger Publishing Company, 1975, pp. 201-211.)

Preparation by the Trainer for the Session

- Review sections of the series: Monograph 2, Chapter II; Monograph 3, Chapters II, V, VI, VII; Monograph 4, Chapters IV, V.
- Utilize recommended major written resources, if desired:
    - Bradford, L., *Making Meetings Work: A Guide for Leaders and Group Members*, La Jolla, University Associates, 1976.
    - Doyle, M. and Strauss, D., *How to Make Meetings Work*, Wyden Books, 1976.
    - Rubin, I.M., Plovnick, M.S., and Fry, R.E., "Running a Better Meeting", in *Improving the Coordination of Care: A Program for Health Team Development*, Cambridge, MA, Ballinger Publishing Company, 1975, pp. 201-211.
    - Schein, E., *Process Consultation: Its Role in Organization Development*, Reading, MA, Addison-Wesley, 1969.

A Model of the Session

Opening Remarks

- Review the previous session and respond to any questions.
- Review the purposes, agenda and expected outcomes of this session, and request group agreement. Determine how many participants completed the assigned homework.
- Respond to any questions.

Presentation

- Present a short statement concerning meetings, the necessity for them, and how to make them more effective. Four questions need to be asked and the answers to them understood about a meeting:*

    - What is the purpose of the meeting? There should be an agenda distributed before the meeting, an agenda review at the beginning of the meeting, and an opportunity for questions.
    - Who is responsible for what in the meeting? Several kinds of leadership are needed, including task-oriented and maintenance-oriented leadership.
    - How is the meeting to be run? Attention needs to be paid to both the goals and the process of the meeting, with a review of the process at the end of the meeting.
    - What kind of participation is needed? Too much participation by some or not enough by others may affect the process if inappropriate to the task or the participants involved.

- Explain that improving the effectiveness of meetings requires the participants to be willing to experiment and change, to try new ideas and to learn from both successes and failures.

- Define the behavioral categories in group dynamics that represent the leadership roles (referred to in the second question above).** In meetings, these roles are in addition to the role of the chairperson (who manages the agenda, the time schedule, etc.).

    - Task-oriented behavior (TOB) - this includes all behavior related to the continued progress on the tasks of the meeting: initiating, information seeking and giving, opinion seeking and giving, clarifying and elaborating, summarizing, and consensus testing.
    - Maintenance-oriented behavior (MOB) - this behavior is concerned with the process - the emotional overtones and undertones in the meeting - and helps keep the participants on track. It includes encouraging, gatekeeping, harmonizing and compromising functions. Conflict is not necessarily eliminated but maintenance-oriented behavior usually requires the group to stop the process and take a look at what is happening in the group.

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* From Rubin, I.M., Plovnick, M.S. and Fry, R.E., "Running a Better Meeting", in Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Company, 1975, pp. 201-211.

** Schein, E., Process Consultation: Its Role in Organization Development, Reading, MA, Addison-Wesley, 1969.

  - Self-oriented behavior (SOB) - this behavior appears when an individual loses sight of what the group is trying to accomplish and either fights to prove a point or drops out, because his/her concern is the self and not the group. This behavior is dysfunctional for the group.

Exercise

- Prepare a chart on the flipchart/blackboard, listing down the left side the TOB and MOB behavioral aspects identified above, and two columns with headings at the top "Do Well Now" and "Do More in Future."

Example of A Meeting Management Behavior Chart

TASK-ORIENTED BEHAVIOR (TOB)	DO WELL NOW	DO MORE IN FUTURE
1. Initiate		
2. Info: Give and Seek		
3. Opinion: Give and Seek		
4. Clarify, Elaborate		
5. Summarize		
6. Consensus Test		

MAINTENANCE-ORIENTED BEHAVIOR (MOB)	DO WELL NOW	DO MORE IN FUTURE
7. Gatekeep		
8. Encourage		
9. Harmonize		
10. Compromise (resolve conflict)		

- Request each participant to identify the team member(s) he or she feels currently do each of the listed behaviors well and to write the names or initials on the flipchart/blackboard opposite each aspect. (Leave blank the "Do More in Future" column.) If a participant feels no one does a particular aspect well, a "O" may be written.

- Facilitate discussion of the completed listing, asking the participants to look for patterns in the chart, such as:
  - Which categories are "heavy" (i.e., well covered by many individuals)?
  - Where is there consensus that one or two persons in the group are responsible for a behavior (i.e., same names appear repeatedly in a particular category)?

- Facilitate discussion of individual behaviors and the identification of those who perform the various functions in meetings.

- Facilitate the discussion by individuals of the behavioral aspects in which they are perceived (by themselves and/or others) to be weak and are willing to practice in order to do more in the future. Clarify the meaning of these aspects, if needed.

- Enter in the "Do More in Future" column on the appropriate line on the chart the names or initials of those committing themselves to strengthen these behavioral aspects. Provide methodological tips and reassurance to those committed and encourage team support of their initial efforts.

Closing Remarks

- Review the session, summarize how the awareness of group process and structure learned in this session will be useful in meeting management, and facilitate evaluation of the session.

- If appropriate, assist the group in allocating behavioral roles to individual members for the next team meeting (not a training session), including chairperson, TOB, and MOB individuals.

- Respond to any questions.

- Confirm the topic for the next session and assign homework, if any.

Session 9. Norms and Monitoring

Purposes of the Session:

- To cover two issues in one session,
- To identify norms (behavioral habits, unwritten rules of behavior) which have become part of the team,
- To develop ways to eliminate undesirable norms and to introduce needed desirable ones, and
- To evaluate the formal training program and to establish procedures to assess progress in team function over time.

Preparation by the Participants for the Session

At the previous session, request participants to read designated information on this topic for this session. (Example: Rubin, I.M., Plovnick, M.S., Fry, R.E., "What It Feels Like To Work Around Here - Planning Next Steps" in *Improving the Coordination of Care: A Program for Health Team Development*, Cambridge, MA, Ballinger Publishing Co., 1975, pp. 173-186, 237-254, 265-279).

Preparation by the Trainer for the Session

- Review sections of the series: Monograph 2, Chapter II; Monograph 3, Chapters II, VI, VII; Monograph 4, Chapters IV, V.
- Utilize recommended major written resources, if desired:
    - Rubin, I.M., Plovnick, M.S., Fry, R.E., "What It Feels Like To Work Around Here - Norms" and "Where Do We Go From Here - Planning Next Steps" in *Improving the Coordination of Care: A Program for Health Team Development*, Cambridge, MA, Ballinger Publishing Co., 1975, pp. 173-186, 237-254, 265-279.

A Model of the Session

Opening Remarks

- Review the previous session and respond to any questions.
- Review the purposes, agenda and expected outcomes of this session, and request group agreement. Determine how many participants completed the assigned homework.
- Respond to any questions.

Presentation

- Present a brief statement concerning norms:

  - Norms are habits or unwritten rules of the organization or of the team which influence the way team members behave and how they feel about their work.
  - Norms of a team may or may not be appropriate to the tasks and goals of the team, and may increase or decrease the effectiveness and efficiency of the team.
  - A team needs to identify and assess its norms periodically, replace dysfunctional ones and develop needed appropriate ones.

Exercise

- Draw two charts on the flipchart/blackboard to assist the participants in understanding norms that influence people's feelings in two areas: recognition/involvement and support/cohesiveness (Rubin, Plounick and Fry, see previous page for citation). Explain these terms by listing alternative responses to them as follows:

Recognition and Involvement

(a) I often get the feeling that some people in the team don't think that some other people on the team have much of a contribution to make. Some people don't pay much attention to the problems or suggestions of others. People are often taken for granted.

(b) Everyone recognizes that the job could not be done without the cooperation and contribution of everyone else. Each person, including myself, is treated as an important part of the team. When you bring up an idea or a problem, people sit up and take notice. It makes you feel that you and your job are important.

Support and Cohesiveness

(a) This job really gets me down. People do not seem concerned with helping each other get the job done. Everyone is pulling in opposite directions, everyone is out for himself. If you try to do something different, you get jumped on by people for being out-of-line. If you make a mistake, you never hear the end of it.

(b) I really like my job, and I like working with this team. The team encourages you to take responsibility. You feel really appreciated by the other members of the team when you do a good job. When things aren't going well, people really make an effort to help each other. We really pull together on this team.

Recognition/Involvement

Good	Bad

Support/Cohesiveness

Good	Bad

- Request each participant to list (perhaps on a piece of flipchart paper) the behaviors he or she has seen or experienced that could lead to "good" or "bad" feelings concerning these two categories. Remind the participants that there is a distinction between role conflicts between two team members and norms of the whole team.
- Ask participants to post these lists on the walls of the room, and to review each others' lists.
- Facilitate a discussion of these lists and the production of a new list of norms that the whole group would like to eliminate, change, or add. Write this list on the flipchart as it develops (or have someone else do so).

- Facilitate the prioritization of the listed norms requiring action.

- Facilitate the establishment of contracts to change dysfunctional behavior and of mechanisms to monitor the proposed changes. Remind the group that feedback is necessary as an endorsement of what is being done as well as an identifier of what to eliminate.

Presentation

- Review the accomplishments of the group during the formal training sessions.

- Present a statement concerning monitoring:

    - In changing norms, as just discussed, monitoring and feedback are needed to ensure that the changes decided on are being done and are benefitting the team. Feedback on areas needing change is no more important than that on areas that are being done well.
    - Similarly, all the issues identified in the data collection and training, and any additional ones that have been addressed in the training, need regular monitoring. The goals and roles established here should be reviewed periodically and, if necessary, modified. Prioritization of problems and assignment of responsibilities for actions to be taken are all part of the monitoring process.
    - The procedures and skills needed in monitoring have already been learned by the participants during the training.

Activity

- Facilitate the scheduling of periodic monitoring sessions in the future.

- Ensure the group understands the monitoring methodology and is comfortable in participating in this process regularly in future without trainer assistance.

Closing Remarks

- Review the session and the training program as a whole and congratulate the group on its progress.
- Facilitate an evaluation of the session and of the total program, and respond to any questions regarding the group's future development.
- Emphasize the need for continuing monitoring and growth.

3. EXAMPLES FROM HOSPICE TRAINING EXPERIENCE: PROCEDURES

The following examples provide a flavor of the training but do not necessarily have applications in all settings. Each hospice site requires specific training to meet its own needs and goals. The inclusion of these examples in this section is not intended in any way to direct or limit the development of the trainer's and the hospice team's own materials. The examples are not verbatim transcripts but are sufficiently accurate to convey the session's content.

(a) Example of the process of reaching role consensus in decision making

The following example is of a discussion in a decision making procedures session as to what role the medical director should play in a particular team decision to be made.

> The medical director (as a position, not myself personally) should be involved in this decision because it makes no sense to give a home health aide a vote and not the medical director a vote. This is a policy decision and the home health aide may have no expertise in it.

* * * * *

> The medical director is saying that he may or may not be affected, but if it is a policy decision, he should be involved.

* * * * *

> We do have job descriptions and the medical director has responsibilities.

* * * * *

> There are two roles for the medical director, one in patient care and the other in top management. But, you may think that here he is patient care and not top management.

* * * * *

> The job description is not what he is doing. If it were, he would be a "D".

* * * * *

> Is everyone following the job descriptions? We should make the decision based on people's roles.

* * * * *

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Meeting Management Behavior Chart

TOB	DO WELL NOW	DO MORE IN FUTURE
1. Initiate	JTJTJTTCAJTAJGGAG	M
2. Info, give and seek	JGJACMGTAMBPLGJABJ PMATCCCG	
3. Opinion, give and seek	JACCMAGTPTGGAGCGJC ABJCG	
4. Clarify, elaborate	JJTTJTTJJG	BC
5. Summarize	JJTATJJTA	BGP
6. Consensus test	JAAAJJAA	BTGP

MOB	DO WELL NOW	DO MORE IN FUTURE
7. Gate keep	PTTOTJ	CAM
8. Encourage	JJMTJCJGJJ	BA
9. Harmonize	BATBMOMB	J
10. Compromise (resolve conflict)	BBMMMMMCOJB	TJ

(c) Trainer Comments on Meeting Management

In these two examples, the first summarizes the trainer's comments on the effect of group dynamics training on group behavior, the second is the trainer's explanation, in response to a question, of the MOB #10, compromise or resolve conflict.

There was an experiment in group dynamics training that took a group of business college students and a group of mental patients, and they had some trained in group dynamics and some untrained in each group. The results showed that the trained mental patients behaved better than untrained business college students. So you see that paying more attention to these aspects will have effects on your productivity.

* * * * *

I'll give you a little lecture on compromise or conflict resolution. One common way to deal with it is avoiding, resulting in a harmonious group as seen from the outside. It's comfortable in the short run, but not for long. Another way is smoothing, "we don't have to fight about this", pouring oil on troubled waters, which is some people's definition of compromise. But if you sweep it under the rug, there is a lump in the rug. It's dysfunctional; it doesn't resolve the issue. Both of these, avoiding and smoothing, are really self-oriented behaviors. The third is forcing, forcing opinions on others - the usual meaning of conflict - a matter of who wins rather than which is the right answer. The problem is, somebody loses and there's hostility and people will not implement the decision and may sabotage it. The fourth one is the usual meaning of compromise. That is splitting the difference; finding something that takes something from each. It may come too soon; you must first see where the difficulty is. Compromise is needed regarding disagreement on basic goals. If what is to be accomplished is clear, it means it can be agreed. A compromise between individual goals and organizational goals is, frequently, inappropriate; people don't want to deal with this. Everybody loses a little. The decision may not be as good as either of the opposing ones. The fifth one is the "right" answer, confrontation, that is, problem solving, solving problems in a rational way, getting all the facts so that you either find solutions to fit everyone's needs or see an alternative that is acceptable to everyone facing the situation. If people are hopelessly in conflict on goals, then it may be a backing off from the decision, a compromise, but you must not do it too soon.

There is one description of different management styles, which states that the task-oriented manager forces, the people-oriented manager smooths, the impoverished manager avoids, and the team-oriented manager confronts.

(d) Examples of Norms

The following is a list of dysfunctional norms that need to be changed, which was developed by a hospice team during a training session on norms.

1. Members feel cut off when discussing issues.
2. Everyone seems to be responsible for everyone's problems.
3. There is no feedback or followup on the patient care meeting suggestions.
4. Thefocus seems to be on crisis conversations.
5. New patients have to be cared for by someone, no matter what.
6. There is hesitancy to give each other either negative or constructive feedback.
7. More specific information is needed on a job well done or not well done.
8. The notices in the nursing room are not disseminated to everyone.
9. Opinions and help are sometimes overwhelming and off target.
10. There's too much distrust regarding information dissemination.

(e) Example of Trainer Comments on Monitoring

The following remarks were made at different points during a training session on monitoring.

> One question we should address is setting up a system to review all of this, perhaps a quarterly review . . . You need to, as a group, look at it, so that you will see a sense of accomplishment and also you may want to add new goals.

* * * * *

> So there will be a monitoring meeting every six months, and then you will set a date for the next six month meeting. You need some sort of calendar system - a constant reminder is a good idea.

* * * * *

It is important to take stock consciously and regularly. It's worthwhile to make it a formal event. The first one should be set for a date in six months. Today is like closure as it is the end of the formal team training sessions, yet it doesn't need to happen because there is so much to do that you can continue to do so on your own.

* * * * *

E. SELECTED REFERENCES FOR TRAINING: PROCEDURES

These materials have been selected for the use of trainers, training participants and others interested in the topic of procedures. They are not specific to hospices but address the principles on which the development of hospice procedures may be based. They identify the positive and negative aspects of the environment and consider these aspects conceptually in terms of their possibility of change.

The documents cited cover all topics included under the heading of procedures that are dealt with in this chapter. They are listed alphabetically by author. When an item is particularly applicable to one or more of the identified issues, it is coded at the end of the citation as follows:

(1) = Decision Making and Problem Solving
(2) = Meeting Management and Group Dynamics
(3) = Norms
(4) = Leadership and Interpersonal Relationships
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APPENDIX

A. Definitions

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C. Table of Contents of Other Five Monographs

APPENDIX A

DEFINITIONS

Meeting the needs of terminally ill patients and their families requires an interdisciplinary and humanistic approach to care. "Meeting needs" infers that the patients and families communicate their needs, directly or indirectly, and that the staff members understand the communication. Staff members also independently recognize patient and family needs and can help them to acknowledge unrecognized yet real needs. The staff then makes every effort to find approaches to meeting the needs.

The patient is recognized as a person with decision making, planning, care delivering and evaluating powers. The family is viewed in the same way. Both patient and family understand their rights and realize that they are in control. They also recognize that they are capable of personal growth through the dying experience. Humanistic patient care is this approach by staff to patients and families. It includes state-of-the-art professional physical care and psychosocial and spiritual support of patients and families as they maintain their independence and their preferred way of life and death.

As the needs of terminally ill patients and their families may be in multiple areas, multiple skills and disciplines must be utilized in any attempt to meet them. The approach, then, must be multidisciplinary. As these needs overlap for the patients and families, and as the solutions to some needs may conflict with solutions to other needs of the same patient and/or family, an interdisciplinary approach is needed. As no one person or profession can meet all the needs, and as no one person can successfully cope alone with the stresses inherent in this work, a team approach is indicated. The patient and family participate as team members. An interdisciplinary team, providing input into assessment, decision making, care and evaluation, with blurring of traditional roles and mutual information sharing and support, has been found to be a most effective approach to terminal care.

1. Interdisciplinary Team

Team activity is not confined to health care nor to any one specific structure. There are board member teams and management teams as well as staff teams. Teams may have consistent membership or may have rotating members; team members may work together with frequent team meetings, or they may seldom meet face to face. Teams may be made up of members of one profession or discipline, or may include more than one profession or a mixture of professions and disciplines. An interdisciplinary team has been defined by Ducanis and Golin* as "a functioning unit, composed of individuals with varied and specialized training, who coordinate their activities to provide services to a client or group of clients". Rubin, Plovnick and Fry** add that coordinating activities requires teamwork. "This need for coordination and working together is called 'interdependence'. Any job that cannot be done by just one person requires some degree of interdependence." (Hospice interdisciplinary teams are discussed at greater length in Monographs 1 and 2.) The Health Resources Administration has defined an interdisciplinary health team as follows:

> INTERDISCIPLINARY HEALTH TEAM is composed of three or more health professionals, including physicians and physician's assistants or nurses, who relate on an equal non-hierarchial basis to each other in the provision of health services to primary, secondary and tertiary care patients. Usually such teams have received didactic and experiential training concerning the roles of other health professionals, interpersonal communications, small group process, other organizational development concepts, and patient/provider relationships. The patient and the patient's family are considered members of the interdisciplinary health team, along with the physician and such staff as physician's assistants, pharmacists, clergy, social workers, psychologists, administrators and volunteers as appropriate.***

2. Humanistic Care

Humanistic patient care is a term used to describe an activity that evades clear definition. In hospice, it has been defined as a timely comfort-oriented focus for patient care and family care delivery . It indicates an increased emphasis on the non-scientific elements of professional patient care (without reducing emphasis on the scientific elements).

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* Ducanis, A. J. and Golin, A. K., The Interdisciplinary Health Care Team, Germantown, Maryland, Aspen Systems Corporation, 1979, page 3.

** Rubin, I. M., Plovnick, M. S., Fry, R. E., Improving the Coordination of Care: A Program for Health Team Development, Cambridge, MA, Ballinger Publishing Co., 1975, page 3.

*** Adapted from: A Discursive Dictionary of Health Care, U.S. House of Representatives, Subcommittee on Health and Environment, 1976.

The Health Resources Administration has defined humanistic patient care by reference to a definition of humanistic medicine:

> HUMANISTIC MEDICINE is medical practice and culture which respects and incorporates the concepts that: the patient is more than his disease, the professional more than a scientifically trained mind using technical skills, both are whole human beings interacting in the healing effort, a person is more than his body, he is a unique, interdependent relationship of body, mind, emotions, culture and spirit; each person has the capacity to define and be increasingly responsible for himself, the professional seeks to assist the patient in taking and fulfilling his responsibility for himself; health and disease are not matters of the moment but have intricate past, present and future; disease, physical, emotional or spiritual pain and suffering, aging and death are meaningful events in an individual's life; and effective health care requires not just conventional skills but also effective development and use of human qualities such as intuition, inventiveness, and sympathy.*

3. Other Definitions

Operative definitions of other terms used in the monographs are provided to ensure clarity of content:

> ORGANIZATION DEVELOPMENT (O.D.) means "an evolving collection of philosophies, concepts, and techniques, which aims at the improvement of organization performance by intervening in social systems (the patterns of social relations existing within a formal organization). Attempted changes may be directed at individuals, dyads, groups, intergroups, formal structures, or cultures. O.D. is not yet a coherent applied science. It derives more from the social than the biological

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* Adapted from: A Discursive Dictionary of Health Care, U.S. House of Representatives, Subcommittee on Health and Environment, 1976.

or physical sciences."*

FACILITATION/FACILITATOR. The verb to facilitate refers "to a process by which events are 'helped to happen'. Facilitating is a kind of influence role which is neither authoritarian, on the one hand, nor abdicative, on the other."**

TRAINER in this series of monographs means the formal leader of the training program sessions, as well as the person conducting the data collection, data analysis, and training program design. This term is used throughout, even though this person is facilitating staff development rather than teaching technical knowledge and skills. As it is recommended that this person be found outside the hospice setting, the person is acting as a consultant to the hospice. The term trainer is used here, therefore, in lieu of the terms consultant, facilitator, process person, change agent, O.D. specialist, or leader.

EXPERIENTIAL AND AFFECTIVE LEARNING. Experiential learning means learning through experiencing within the group, and then analyzing and generalizing from the experience. The experience may be actual or simulated (through role playing, or through video taping of group members' interactions). It refers to experiences presently taking place within the group members (not reporting of experiences that have taken place with others). Affective learning implies emotional learning (as in the heightening of awareness) rather than cognitive learning, and includes exploring and generalizing feelings. It may refer to either individual or group learning.

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* Vaill, P. B., "An Informal Glossary of Terms and Phrases in Organization Development", in Jones, J. E. and Pfeiffer, J. W. (editors), The 1973 Annual Handbook for Group Facilitators, La Jolla, CA, University Associates, 1973, reprinted with permission in Weisbord, M. R., Organizational Diagnosis, A Workbook of Theory and Practice, Reading, MA, Addison-Wesley Publishing Company, 1978, page 75.

** ibid, page 73.

APPENDIX B

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